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ABSTRACT

This monograph discusses runaway and homeless youth and the programs that serve them in seven large and medium-sized cities throughout the United States. The monograph focuses on the characteristics and service needs of these youths and the demands they pose for service providers. It examines how the population and the service environment have changed since passage of the Runaway and Homeless Youth Act of 1974 and whether public policies and practices have kept pace with these changes. It looks at social and practice issues confronting providers and policymakers and highlights viable strategies that have been developed by programs to serve this population of youth effectively. This monograph is based on in-depth examinations of programs in Albuquerque, New Mexico; Boston, Massachusetts; Chicago, Illinois; Des Moines, Iowa; Iowa City, Iowa; San Diego, California; and Seattle, Washington. During site visits extensive interviews were conducted with staff and funders. The following issues were discussed: (1) essential services, including substance abuse prevention, mental health, Acquired Immune Deficiency Syndrome (AIDS) prevention and education, medical and dental care, housing, emergency shelter, education, and employment and training; (2) organizational issues and strategies including policies and values, boards of directors, staff recruitment, management information, research and evaluation, volunteers, and youth and family involvement; (3) funding; and (4) interagency collaboration. References are included. Nine appendices include a list of the programs studied, excerpts from AIDS education manuals and policy and procedures manuals, and various documents specifically pertaining to individual programs. (ABL)

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ON THEIR OWN

RUNAWAY AND HOMELESS YOUTH AND PROGRAMS THAT SERVE THEM

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PREFACE

A small, copper-skinned youth, who looks far younger than his thirteen years, grinned broadly as he ate his evening snack with the other young people at The Storefront emergency shelter in downtown San Diego. Raul (not his real name) spoke very little English, but tried extremely hard to learn a couple of words as we conversed in Spanish. Raul slept in a secluded section of Balboa Park until a friend took him to a social service agency for Hispanic youth which referred him to The Storefront. Raul explained that the park was a good place to hide from the INS worker who chased him because he was afraid to go into the deep recesses of the park to catch him. What Raul failed to say was that the park was a very dangerous place where homeless kids were raped, beaten and robbed. Before coming to San Diego, Raul lived on the streets of Mexico City from the time he was a small child.

The following morning at the Homeless Outreach School, Raul continued his persistent effort to learn English, as he toiled over a worksheet matching simple words with pictures. It was overwhelmingly sad to imagine this tiny, engaging, yet vulnerable, young boy exchanging sex for cash or a meal, but that was how he had been surviving on the streets.

Over dinner at the Orion Center in Seattle, David (not his real name), an eighteen-year-old gay youth, recounted how his mother and his new stepfather had thrown him out of the house because they felt that his sexual preference violated the strict moral beliefs of their newly-found religion. In spite of repeated efforts by YouthCare staff, his mother refused to take him back into the house or to attend family counseling. With a certain amount of feigned bravado, this young man said he knew he could make it on his own and "didn't need them anyway".

A petite, attractive 20-year-old, I'll call Amanda, introduced herself and proudly shared her plans for the next fall. This young woman, after attending the Homeless Outreach School, had received her GED and was planning to attend the local community college. With obvious pride, this articulate, bright young woman talked about when she left home and just how long it took to get to the point where she worked things out. At that time she reported she was in frequent contact with her family and they were pleased about her plans for college. With the wages from her full-time waitressing job, she would be able to rent her own apartment. When asked to what she attributed her success, she smiled warmly and said support from her teacher there at the school, the staff at San Diego Youth and Community Services (SDYCS), and contact with her younger sister, for whom she wanted to be a good role model.

Raul, David and Amanda are in some obvious ways very different people, and yet they do have one very important thing in common. These three youth found their way to programs that cared about them and responded to their unique needs and problems. One of the most significant things about these programs, the five other programs described in this document, and the many other programs throughout the country not described here is that they focus on the strengths of these youth and, whenever possible, the strengths of their families.

Phyllis Magrab, Ph.D. and myself at the Georgetown University, Child Development Center, CASSP Technical Assistance Center, along with Barry S. Brown, Ph.D. at the National Institute on Drug Abuse (NIDA), Jean Garrison-Athey, Ph.D. and Ira Lourie, M.D., both formerly of the National Institute of Mental Health (NIMH), recognize and appreciate the many heros and "sheros" working in the trenches; working the graveyard shifts; spending holidays away from families and loved ones in order to be with kids who are also away from families and loved ones; walking the "mean streets" as outreach workers in neighborhoods most of us never venture into and want to pretend don't exist; distributing condoms to kids and educating them about preventing a disease, AIDS, that can kill them; spending endless hours counseling parents who are frustrated and frightened; writing proposals for funding with endless requirements, but which will last only one year and only partially fund the services that are provided. For those things and the countless other work they do, we thank them.

It is our belief that because this monograph so clearly describes who homeless and runaway youth are, what their needs are, and the kinds of services that are being provided in seven communities around the country, service providers will have the opportunity to learn about some of the strategies employed by their creative colleagues, and policymakers can gain a greater understanding about what is being done and what else we need to do for our children who are in pain.

Diane M. Doherty, MSW, LICSW
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Georgetown University Child Development Center

ACKNOWLEDGEMENTS

The runaway and homeless youth in the seven cities we visited deserve special thanks for their willingness to share their stories with us. The line staff, executive directors and board members at the programs we visited also were extraordinarily generous in giving us their time, wisdom and insight, which helped us to understand the youth they serve. We want to thank, as well, the many other community representatives with whom we met in each city.

The advisory panel that guided this project from the beginning was crucial in helping us to identify the values and principles that characterize effective service delivery for youth at risk. Similarly, the advisory panel's recommendations of programs to be included in **On Their Own** was invaluable.

Special recognition is due to Diane Doherty, Director of the Children and Youth At Risk Project at Georgetown University, for her dedication to runaway and homeless youth and for her foresight in initiating this project. Also, we want to thank John O. Woodruff, formerly with the Children and Youth At Risk Project, for the many hours of staff support he devoted to **On Their Own.**

We are particularly grateful to Barry Brown of the National Institute on Drug Abuse and Ira Lourie, M.D. of the National Institute of Mental Health for their support in underwriting the cost of the project, as well as for their continued leadership on behalf of youth at risk.

Finally, we owe Rita Leahy our sincere appreciation for her skill and patience in typing numerous drafts of this manuscript.

Sheila A. Pires
Judith Tolmach Silber

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CHAPTER I.

INTRODUCTION

BACKGROUND

Runaway and homeless youth, despite their large numbers, are considered the most understudied subgroup among the homeless population, according to the Institute of Medicine (1989). **On Their Own** is a report on runaway and homeless youth, and programs serving them, in seven large and medium-sized cities throughout the United States. The monograph focuses on the characteristics and service needs of these youth and the demands they pose for service providers. It examines how the population and the service environment have changed since passage of the Runaway and Homeless Youth Act in 1974 and whether public policies and practices have kept pace with these changes. It looks at social and practice issues confronting providers and policy makers and highlights viable strategies that have been developed by programs to serve this population of youth effectively.

The title, **On Their Own**, was chosen to convey both the strength and the vulnerability of runaway and homeless youth and of the programs that serve them. This population, perhaps more than any other, lacks mainstream support systems. Families, schools, communities, social welfare systems—the traditional support structures—in various ways, have disintegrated in the lives of these adolescents. Yet, despite their vulnerability, these youth display extraordinary resolve and ability to survive.

Effective runaway and homeless youth programs share similarities with the youth they serve. They also struggle for support and understanding, as well as survival. The traditional service delivery systems, whether education, child welfare, mental health or health care, have been slow to respond to runaway and homeless youth. In their stead, an alternative network of community-based agencies has evolved. Though often on their own, alternative youth programs have developed remarkably creative services and usually take the lead in forging alliances with

mainstream systems. A goal of this monograph is to encourage more integration between mainstream service systems and alternative youth programs by documenting the need, discussing the barriers, and describing effective partnerships in the cities we visited.

On Their Own itself represents a collaboration among the National Institute on Drug Abuse (NIDA), the National Institute of Mental Health (NIMH) and the Maternal and Child Health Bureau (MCH), who initiated the report out of concern for the high degree of risk for substance abuse, serious emotional disturbance and HIV infection in this population. The monograph pays particular attention to these areas of concern.

METHODOLOGY

On Their Own is based on an in-depth look at seven programs recommended by a panel of experts convened by the Children and Youth at Risk Project of the CASSP Technical Assistance Center, Georgetown University, at the request of NIDA and NIMH. This advisory panel was comprised of individuals representing service providers, policy makers, researchers and advocates.[1]

The advisory panel met for a day at Georgetown University to develop recommendations regarding policy and practice issues and to identify effective programs for site visits. Prior to site visits, telephone interviews were conducted with the programs recommended by the advisory panel, utilizing a questionnaire to record program and policy information. In addition, written materials from each of the programs were collected and reviewed, which described program, staff and youth characteristics, funding sources, interagency collaborations and policy issues.

Site visits, which averaged three days each, were made by two-person teams to seven programs in the following cities: Albuquerque, Boston, Chicago, Des Moines, Iowa City, San Diego and Seattle. During the site visits, extensive interviews were conducted with board members, executive directors, program managers, line staff, youth and funders at each of the

[1]See Appendix A for list of advisory panel members.

programs. Additional interviews were held with community representatives, including police and hospital personnel, public agency staff, particularly staff from the child welfare, mental health and juvenile justice and substance abuse systems, and advocates. After the site visits, follow-up telephone interviews were conducted and material collected as necessary to clarify or obtain specific information.

Interviews also were conducted with staff from the National Network on Runaway and Youth Services and from the National Runaway Switchboard. In all, over 200 individuals were interviewed for **On Their Own.**

A review of current literature on runaway and homeless youth was made to refine further the information gathered from the advisory panel, the questionnaire, written materials collected from the programs, the site visits and telephone interviews.

A draft of **On Their Own** was reviewed by the seven programs included in the report, the advisory panel, and staff at the National Institute on Drug Abuse, the National Institute of Mental Health, the Maternal and Child Health Bureau and the Georgetown University Child Development Center.

Neither the advisory panel nor the authors intend to suggest that there are only seven programs worth examining. On the contrary, it is remarkable, given the difficulty of serving this population and the economics of providing alternative youth services, that there are many good programs—although not *enough* services—throughout the country. Only constraints of time and funding prevented inclusion of additional programs in this report.

SYSTEM OF CARE PRINCIPLES

A number of principles pertaining to effective service delivery for this population informed the work of the advisory panel and guided site selection. Many of these principles derive from the system of care philosophy and service elements delineated by Stroul and Friedman (1986) for NIMH's Child and Adolescent Service System Program (CASSP). Others stem from the

experience of researchers and service providers focusing on runaway and homeless youth (Boyer, 1988).

These principles and service elements are fundamental goals toward which good programs strive. In reality, no program has achieved all these elements. The aim of the advisory panel was to recommend programs that "looked more full than empty" in their commitment to and operationalizing of these principles. The panel also was concerned that there be some geographic balance, representation from large, as well as small- to medium-sized cities, and inclusion of programs that reach both urban and rural youth populations.

The principles that guided the advisory panel's discussion of effective service delivery are:

1. **Adolescent-centered:** Adapts services to the adolescent, rather than expecting the adolescent to adapt to the services.

2. **Community-based:** Provides local, integrated and coordinated services.

3. **Comprehensive:** Recognizes the multiple needs of these youth and ensures comprehensive services and holistic care.

4. **Collaborative:** Draws on the resources of a community or works in coordination with other programs to provide a range of services, in-house or through interagency agreements.

5. **Egalitarian:** Provides services in an environment and a manner that enhances the self-worth and dignity of adolescents; respects their wishes and individual goals.

6. **Empowering:** Maximizes opportunities for youth involvement and self-determination in the planning and delivery of services, and fosters a sense of personal efficacy that encourages youth to want to effect changes in their lives.

7. **Inclusive:** Serves all runaway and homeless youth or provides and tracks referrals for those youth whom the program is unable to serve.

8. **Visible, Accessible and Engaging:** Provides services that attract youth.

9. **Flexible:** Incorporates flexibility in service provision and funding to support individualized services.

10. **Culturally Sensitive:** Works to provide culturally competent services.

11. **Family-Focused:** Recognizes the pivotal role that families play in the lives of high-risk adolescents.

12. **Affirming:** Targets strengths, not deficits, of youth and their families.

In addition to these principles, the advisory panel recognized the following range of services as necessary to meet the needs of these multi-problem youth: Outreach; Housing; Substance Abuse Services; HIV Prevention, Education and Treatment; Health and Dental Care; Mental Health Services; Employment and Training; Education Services; Case Management; and Advocacy.

PURPOSE OF MONOGRAPH

On Their Own is intended to reach several audiences and serve a number of purposes. It is a technical assistance document for service providers looking for ways to strengthen or add to their programs in the face of today's economic and social realities. We hope it will foster greater exchange of information among providers and encourage more program-to-program technical assistance, which is one of the most effective forms of knowledge and skills transfer.

On Their Own also is meant to be a teaching tool for policy makers regarding the service needs of runaway and homeless youth, the barriers faced by providers and the viable program strategies that should be considered for replication. It is hoped that the monograph will foster greater communication and understanding between practitioners and policy makers.

On Their Own also should be of interest to the research community in suggesting areas for study related to this population and the programs that serve them. There is a critical need for universities, practitioners and policy makers to come together around issues relating to runaway and homeless youth.

It is hoped that advocates also will find this monograph useful in their continuing effort to draw attention to the needs of runaway and homeless youth.

Perhaps the most compelling aim of the monograph is to encourage greater collaboration between traditional service delivery systems (i.e., child welfare, juvenile justice, education, mental health and health care) and alternative youth services programs. The fragmented nature of traditional service systems—a barrier described for over 20 years in the youth services field—continues to frustrate comprehensive service delivery for multi-problem adolescents. The inherent financial precariousness of alternative programs—also a reality for over 20 years—continues to impede stability in service delivery. Runaway and homeless youth will continue to go unserved and underserved unless traditional systems and alternative programs join forces to create a stable, comprehensive system of care.

In the decade ahead, the problems of runaway and homeless youth and the programs that serve them are unlikely to diminish. If, in the 1990s, the nation continues to experience persistent child poverty, family disarray, housing shortages and joblessness, the attendant problems of substance abuse, emotional disturbance and homelessness also will persist. If, as seems likely, there continue to be scarce resources to alleviate these problems, youth service providers will continue to face an impossible task.

The 1980s were a decade devoted to documenting the multiple problems of children, youth and families and the badly fragmented service system that fails them. The 1980s saw consensus for a "new model of adolescent service delivery" (Kamerman and Kahn, 1989) that encompasses comprehensive, holistic, individualized, flexible, community-based, family-centered, culturally sensitive care. The 1990s must be a time to translate these values into practice. This will only happen if alternative programs and public systems seriously explore—and take the risk to develop—an integrated youth services system. Neither alternative youth programs, public service systems, nor the youth they serve, can overcome the realities of the 1990s on their own.

In the seven cities we visited, there are examples of collaboration between alternative and public agencies that are the beginning of meaningful systemic change. Diversion of juvenile prostitutes from detention to alternative services is an example of systemic change. So is educating street youth in public school-supported alternative classrooms that adapt to, rather than indict, difficult behaviors. Such examples of collaboration, and others like them throughout this

monograph, depend on a shared vision: that youth and their families have strengths to nurture, instead of deficits to contain.

Although major changes in public policy are needed before there is an integrated system of support for youth at risk, the programs we visited and the public systems with which they collaborate did not wait for broad systems change before embarking on new ways to serve youth. *The strategies they have implemented* ***can*** *be adapted in communities throughout the country, even as we continue to advocate for major policy change.*

OVERVIEW OF PROGRAMS

The programs that were selected for inclusion in this report are:

Bridge Over Troubled Waters, Boston, Massachusetts
Iowa Homeless Youth Center, Des Moines, Iowa
Neon Street Center for Youth, Chicago, Illinois
San Diego Youth and Community Services, San Diego, California
United Action for Youth, Iowa City, Iowa
Youth Development, Inc., Albuquerque, New Mexico
YouthCare, Seattle, Washington

An overview of each of these programs follows; a list of program addresses, telephone numbers and contact persons can be found in Appendix B. The intent of this monograph, however, is not to profile each program in its entirety. Rather, it is to use the experience of these providers to: identify viable strategies across a number of essential service, organizational and funding areas; describe runaway and homeless youth today; illustrate the demands on providers; and, draw policy and practice implications. Therefore, the program descriptions that follow are brief overviews only. Greater detail is reserved for the specific strategies drawn from the programs that are described throughout the monograph.

Bridge Over Troubled Waters
Boston, Massachusetts

Bridge Over Troubled Waters (hereafter referred to as Bridge), with headquarters in downtown Boston, opened in 1970 to provide street outreach to runaway and homeless youth. Today, it is a comprehensive, multi-service, private, nonprofit agency, governed by a board of directors, with a $1.5 million budget. It employs 38 full-time staff, 3 part-time staff and over 200 volunteers.

Bridge's major service components include:

- Street work outreach;
- Runaway crisis counseling and emergency shelter through 20 "host homes";
- Substance abuse counseling;
- Center for pre-natal care and parenting training;
- Mobile medical van;
- Dental clinic;
- Education and pre-employment services;
- Transitional housing facility for 16- to 21-year-old homeless youth;
- Transitional housing facility for 16- to 21-year-old mothers and their babies;
- Cooperative apartments for 18- to 21-year-old youth;
- AIDS prevention and education services; and,
- Drop-in center.

Bridge serves street youth and youth living in the community ranging in age from 13 to 25, but its primary target population is homeless adolescents, ages 16 to 21.[2] Most are white and

[2]Chapter III provides an in-depth description of the youth served by each program.

from the Greater Boston area, but Bridge is seeing an increasing percentage of African American youth (now 54%) as well. Bridge comes into contact with roughly 3,000 youth a year through its outreach programs and engages about 2,300 youth a year in services.

Bridge creates an atmosphere of tolerance and respect for youth, offering services in a low-key, non-intrusive manner; in return, Bridge expects youth who become involved in services to act responsibly and dependably. The program uses survival services, such as food and clothing, as a means to draw youth into more empowering kinds of services, such as counseling and education.

Bridge is a comprehensive program that provides most of its services in-house, rather than arranging them through other agencies. However, it draws extensively on community resources for funding and volunteer support (particularly from the medical and dental professions to staff the medical van and dental clinic). Over 60% of Bridge's budget is supported by private dollars (individual contributions, foundation grants and United Way); the remainder (about 40% of the budget) is comprised of federal, state and city grants and contracts.

Bridge's main facility is located in downtown Boston. Its transitional living program for mothers and babies and its cooperative apartments are housed in a three-building site in a residential neighborhood, which Bridge purchased in 1986 and renovated extensively. Its transitional living residence for 16- to 21-year-olds is located in a former rectory leased to Bridge by the Catholic Archdiocese of Boston for a nominal fee.

The Iowa Homeless Youth Center
Des Moines, Iowa

In 1986 the Iowa Homeless Youth Center (IHYC) began providing services to runaway and homeless youth housed at the local YMCA. A street outreach project was added in 1989. In 1990, IHYC opened a seven-bed transitional living center for teens 16 to 20, substantially expanding its services, which now reach three populations of homeless and runaway teens:

Street outreach van with medical screening for chronic street youth;

- Transitional living center for eight youth at risk of becoming homeless; and,

- Independent living apartments for seven teens who have "graduated" from the transitional living center.

At its transitional living center, IHYC's primary population is composed of runaway youth, 98% of whom have been turned down by the traditional child-serving systems because of their age or prior history; most IHYC youth are white and at risk of homelessness, but not yet chronic street youth.

The Iowa Homeless Youth Center is one of 14 projects throughout the State of Iowa that are administered by Youth and Shelter Services, Inc. (YSS), located in Ames, Iowa. YSS was founded in 1975 to "promote family life enrichment, early intervention and prevention of substance abuse and delinquency." IHYC receives funds, administrative assistance and clinical supervision from YSS and the YSS Foundation in Ames.

IHYC was able to purchase a house near downtown Des Moines for its transitional living center after receiving two federal grants: a five-year grant from the U.S. Department of Housing and Urban Development and a two-year grant from the U.S. Department of Health and Human Services. These two federal grants constitute more than 50% of IHYC's current budget, but since both are time-limited, IHYC's Advisory Board is engaged in an active fundraising campaign.

IHYC's transitional living center has a full-time staff of six and several part-time (week-end) staff who provide comprehensive on-site services, including mental health counseling, vocational counseling, training in independent living and drug counseling to all residents, who are also required to attend high school and to work.

The Iowa Homeless Youth Center also operates a mobile outreach van, staffed with two youth workers, that travels the streets of Des Moines, offering food, survival kits, crisis counseling, emergency medical care, and referral information to more than 400 teens annually.

Although IHYC's residential component serves a relatively small number of youth, it provides an important link in a network of public and private nonprofit youth service agencies that are actively working together to create a comprehensive system of services for Des Moines youth.

Neon Street Center for Youth
Chicago, Illinois

Neon Street Center for Youth (hereafter referred to as Neon Street), located in Chicago's Lakeview District, started in 1986 as a drop-in center for homeless youth. The impetus behind Neon Street was a 1985 report by a Governor's Task Force indicating that there were some 10,000 homeless youth, largely unserved, on Chicago streets. Neon Street was started by and remains a component of Travelers and Immigrants Aid of Chicago and has strong connections to the adult homeless shelter provider community, which advocated for its creation.

Neon Street serves about 500 runaway and homeless youth, ages 13 to 21, but its principal target group is 18- to 21-year-old homeless adolescents. About half of its population are white; half are minorities, mostly African Americans, and most are from the Chicago metropolitan or suburban area.

Today, four and a half years after its start, Neon Street has added multiple service components, either in-house or by interagency agreement. Neon Street provides the following services in-house:

- Drop-in center;
- Emergency shelter facility for runaway youth, ages 13 to 18;
- Transitional housing facility for homeless youth, ages 18 to 21;
- Substance abuse counseling;
- AIDS prevention and education services;
- Education services; and,
- Pre-vocational services.

In addition, Neon Street has 40 formal, written agreements with other agencies to provide other needed services—such as medical care—that Neon Street does not itself provide.

Neon Street employs 28 staff and utilizes over 40 volunteers. Its budget is approximately $700,000, about three-quarters of which is comprised of federal, state and city grants and contracts.

Neon Street's philosophy, like that of its parent agency, Travelers and Immigrants Aid, is to help youth to meet basic needs, strengthen their capacity for self-sufficiency and assist them to achieve self-reliance and full participation in society.

San Diego Youth and Community Services
San Diego, California

San Diego Youth and Community Services (SDYCS), a nonprofit organization founded in 1970, operates nine neighborhood-based projects with a staff of 150 and over 500 volunteers. Four of its projects provide services to runaway, homeless or at-risk youth and include the following components:

- A shelter for 13- to 18-year-old youth with a street outreach van that operates throughout the county;
- Two short-term group homes for 12- to 18-year-old runaways at risk of homelessness;
- An alcohol and drug abuse day treatment program with a drug prevention drop-in center;
- A county-wide AIDS education and staff training program;
- An alternative school for homeless teens;
- A hotline;
- Runaway prevention and family reconciliation services;
- Culturally competent services for youth of color;

- Gang prevention and intervention; and
- An independent living program housed in small cottages.

The Storefront, a teen shelter which opened its doors in 1988, is the largest facility in the SDYCS network of services for high-risk youth. With a mandate from the State of California's Office of Criminal Justice Planning to "prevent child sexual exploitation", The Storefront has a program that provides comprehensive services and overnight shelter, for as long as six months, to give young prostitutes and homeless adolescents a realistic chance of leaving the streets permanently. The shelter also accommodates those teens who only want a one-night respite from street life.

In 1989, The Storefront sheltered 550 street youth and made contact with another 1,500 youngsters through its outreach van. Over 40% of The Storefront's population are Asian, African American or Hispanic and include youth from all over the country, as well as illegal aliens.

The Storefront, which has a staff of eight and a $400,000 annual budget, receives 50% of its funding from the state; an additional $200,000 is raised from foundations, private donors and city contracts. The 1990 budget for all SDYCS projects was $4.8 million.

Two other SDYCS programs, the *Bridge* and the *Gatehouse,* both short-term, 14-bed group homes, also provide shelter to troubled teenagers who may have spent a short time on the streets, but, typically, the group home teens are not yet committed to street life. In contrast to youth at The Storefront, Bridge and Gatehouse teens are predominantly white and from the San Diego area.

The Storefront, the Bridge and the Gatehouse offer a wide array of services to their youth through a network of agreements that SDYCS has negotiated with more than 60 local agencies.

United Action for Youth
Iowa City, Iowa

United Action for Youth (UAY) has been providing youth services in Johnson County and eastern Iowa since 1970. In its early years, UAY's principal focus was the prevention of juvenile delinquency. In 1987, using Community Development Block Grant funds, UAY purchased and renovated a 19th century home in the center of Iowa City. Called the Youth Center, the program's new facility has provided greater stability and visibility.

UAY's components include:

- Drop-in center;
- Creative arts workshop;
- Crisis hot-line;
- In-home family preservation services;
- Rural outreach counseling;
- Individual and family therapy;
- Parent training;
- Recreation and sports activities;
- AIDS/HIV education;
- Parent training for teens; and
- Victims support program.

UAY's primary purpose—to assist young people and their families in resolving their problems—is typical of many youth service programs, but UAY accomplishes its objective with a unique mixture of traditional therapeutic intervention and opportunities for artistic expression, including an art, music and video studio, a theatre troupe and a literary magazine. Because the Youth Center is open to all teenagers in the community, not just troubled youth, it functions as both a prevention and intervention program.

In 1989, UAY served 825 youth and their families with a staff of 15 full-time employees. Although runaway and homeless youth comprise 15% of the agency's caseload, Iowa City's police and parole officers consider UAY their principal resource when seeking assistance for homeless youth, or any youth at risk of court intervention or homelessness.

UAY's services are provided in a variety of settings in Iowa City and in the outlying rural counties, including schools, shelters, a youth's own home, recreation centers and the county juvenile detention facility where they work to divert youth to alternative services. Rather than providing comprehensive care exclusively through its own auspices, UAY has forged alliances with a network of agencies.

UAY is a private, nonprofit agency governed by a Board of Directors representative of a cross-section of Iowa City citizens. In 1989, the annual cash budget of the agency was $340,595, with an additional $34,000 in in-kind contributions. Local and state grants and contracts comprise a major share of UAY's budget; federal funds account for 25% of annual expenditures.

Youth Development, Inc.
Albuquerque, New Mexico

Youth Development, Inc., located in Albuquerque's South Valley, opened in 1971 as an outreach program for youth "drop-outs". Today, YDI is a comprehensive program, offering an array of prevention, early intervention and treatment services targeted to at-risk children and youth and their families and neighborhoods. YDI is a private, nonprofit agency governed by a Board of Directors.

YDI targets, not only runaway and homeless teens, but children, youth and their families living in Albuquerque's poorest neighborhoods, and, in particular, Hispanic youth and families in the barrios of the South Valley area. YDI serves about 1,300 individual youth a year and comes into contact with another several thousand through its extensive outreach activities. Most are 15- to 19-year-olds, and two-thirds are Hispanic.

YDI's major service components include:

- Outreach to three housing projects; includes community organizing, gang intervention, substance abuse prevention and education;
- After school, summer recreation and latchkey programs;
- Juvenile diversion for court-ordered youth;
- Gang intervention project;
- School drop-out prevention;
- GED preparation;
- Emergency shelter facility for runaway youth, 13 to 18 years old;
- Longer stay shelter facility for chronic runaway and homeless youth, ages 13 to 18;
- Residential treatment facility for children, ages 10 to 15, who have serious emotional disturbances;
- Substance abuse prevention and education through music and the arts;
- AIDS prevention and education services targeted to youth and a program targeted to Hispanic intravenous drug users and their families;
- Youth center in a housing project;
- Youth-run businesses;
- Summer youth employment program;
- Economic development; and
- Independent living and housing programs for homeless youth and families.

YDI is committed to working with youth in their homes and neighborhoods, where their problems originate. The program promotes activities, such as neighborhood clean-ups, youth-run businesses and youth theatre groups, that empower the communities and youth they serve, focusing on their strengths, rather than just on problems.

YDI utilizes 93 staff and over 100 volunteers, many of whom, including the Executive Director, come from the neighborhoods the program targets. The agency's $2.3 million budget draws on a wide variety of federal, state, county, city and private dollars.

YDI provides comprehensive services, for the most part, in-house, rather than arranging them through other agencies. However, it does barter for some services, such as health care, and it participates actively in state and city-wide consortia of service providers to avoid duplication and foster coordination, as well as for advocacy purposes. Also, YDI draws heavily on community resources for funding, jobs and volunteers.

YouthCare
Seattle, Washington

YouthCare (formerly Seattle Youth and Community Services), with headquarters in downtown Seattle, started in 1974 as an emergency shelter for runaway youth. Today, it offers comprehensive services, continuing to target street youth, with a particular emphasis on juveniles engaged in prostitution.

YouthCare's major service components include:

- Street work outreach;
- Drop-in center;
- Emergency shelter for runaway youth, ages 11 to 17;
- Transitional housing facility for 16- to 18-year-old girls involved in or at risk of prostitution;
- Transitional housing facility for 18- to 21-year-old homeless youth;
- AIDS education and prevention services;
- Alternative education and pre-employment services;
- Health services;
- Gang intervention services;

- Intensive case management; and
- Research and evaluation.

YouthCare has strong collaborative agreements in place with other organizations and agencies to provide certain key services. Specifically, the education component is run jointly with Seattle Public Schools; health services are provided in collaboration with the Adolescent Clinic at the University of Washington and the Health Care to the Homeless Program; the gang intervention project represents a collaboration among 24 agencies.

YouthCare serves about 1,200 individual youth a year and comes into contact with another approximately 3,000 through its street work and AIDS outreach activities. Most are under 18 and are chronic street youth. Most are white, although YouthCare is serving an increasing percentage (about 40%) of minority youth.

YouthCare employs 63 staff directly, and approximately 20 other staff work in the program through collaborative agreements. For example, teachers are outstationed from Seattle Public Schools. Its budget is about $2.5 million, roughly 80% of which is comprised of federal, state, county and city grants.

YouthCare believes that youth should and can take responsibility for the quality of their lives. It views its services as a means to reduce the chaos in the lives of street youth so that they can begin to realize their potential.

CHAPTER II.

RUNAWAY AND HOMELESS YOUTH: CHANGES IN THE POPULATION AND THE SERVICE ENVIRONMENT

Clinicians writing in the 1970s tended to divide runaway and homeless youth into two groups: those who left home as a result of their own psychopathology and those who ran away to escape a pathological home situation (Speck, et al., 1988). There was an assumption that most youth fell into the former category. It was logical, then, to assume that most youth who left home, with the appropriate short-term assistance, could change their behavior and return home. This was the logic that influenced the 1974 Runaway and Homeless Youth Act, whose original purpose was to provide crisis intervention, short-term emergency shelter, limited to a maximum of 15 days, and family reunification services (U.S. General Accounting Office, 1989). The Act, in turn, encouraged development in the 1970s of a network of runaway and homeless youth shelters that provided emergency shelter and crisis intervention services designed to help youth return home.

Since passage of the Runaway and Homeless Youth Act, there have been enormous structural changes in the American family, in the economy, in neighborhood social support systems and in institutions, such as business and the schools, that have contributed to profound changes in the nature of the runaway and homeless youth population. Changes in the population, in turn, have placed many new demands on service providers, which have altered considerably the profile of today's runaway and homeless youth program. As a case in point, in every program we visited, short-term emergency shelter and crisis intervention services—the service mainstays of the Runaway and Homeless Youth Act—have become a relatively small part of the total array of services that agencies now provide.

Today's runaway and homeless youth programs struggle with a dichotomy inherent in the population they serve. Runaway and homeless youth do not fit a single mold: although some have families to which they can return, a seemingly increasing number do not. Practitioners must

strike a difficult balance between investing in efforts to preserve families and efforts to support responsible independence when family reunification is not probable.

Maintaining both options for youth of different ages with different needs is difficult for many reasons. There is no recipe for recognizing which youth and families can be reunified. Often, it is not possible to predict whether family preservation is possible until it has been tried. At the same time, however, resources are limited. Should the bulk of resources be devoted to an array of family preservation services or to a range of housing, education and employment options for youth to live independently? Should staff be hired who have family preservation skills or expertise in developing independent living programs?

At the seven programs we visited, family reunification remains a goal and the focus of services for some of the youth served. However, for what seems to be a growing number of youth served by these programs, the goal is independence with *reconciliation of family issues* but not reunification of family members. With the kinds of changes in today's youth and families discussed in this chapter, programs assert that both family reunification and independence with reconciliation of family issues are needed options; more importantly, programs affirm that both options require an intensive and comprehensive array of services.

The complex, deep-seated nature of the problems of today's runaway and homeless youth—serious educational and employment deficits, substance abuse, emotional trauma and depression, HIV infection, persistent health and dental problems, pregnancy and parenthood, poverty and homelessness, as well as the problems of their families—cannot be resolved in the short-term. Unfortunately, neither the Runaway and Homeless Youth Act nor other federal youth and family policies have adequately responded to, much less anticipated, these realities. As a result, providers are struggling to provide long-term, comprehensive solutions with short-term, categorical supports.

Tulane University sociologist James D. Wright recently noted that homelessness is

> ... simultaneously a housing problem, an employment problem, a demographic problem, a problem of social disaffiliation, a mental health problem, a family violence problem, a problem created by the cutbacks in

> social welfare spending, a problem resulting from the decay of the traditional nuclear family, and a problem intimately connected to the recent increase in the number of persons living below the poverty level.
>
> (Wright, 1988.)

While Wright is referring to homelessness in general, his point is very applicable to runaway and homeless youth in particular. More than any other adjective, "multi-problem" is used by researchers and practitioners to describe runaway and homeless youth, referring both to the environments from which they come and to the problems they bring with them. As one staff person told us: "Our kids are at risk for everything."

At all of the sites we visited, board members, executive directors, staff, community representatives and youth described a strikingly similar constellation of problems that characterize runaway and homeless youth and the circumstances that surround their lives. As noted in Chapter III, there is this consistency despite the diversity of youth across all of the programs with respect to age, race, gender, economics or sub-culture.

FAMILY CHANGES

Schorr (1988) writes about the pivotal role that families play in the lives of children:

> Children whose memories are storehouses of deprivation, neglect, or violence are robbed of the ability to cope with the present or to envision a future bright enough to justify postponing immediate rewards. Children whose families were never able to convey to them a sense of being valued and a feeling of coherence are in a poor position to cope with the world of school or work. They are likely to be in deep trouble by the time they become adolescents.

A theme we heard repeatedly from programs was the influence of changes in family structure on the runaway and homeless youth population. Programs and staff consistently cited the following changes over the last decade with respect to families:

- Very few youth who leave home come from traditional, nuclear families. Instead, there are many more single-headed households (divorce or never

married); more blended families through divorce and remarriage (with step-fathers, step-mothers, and step-siblings); more youth are living in loosely structured extended families.

- Families are more isolated due to changes in family structure, such as divorce, and neighborhood deterioration, which has weakened ties to community organizations, particularly the churches.

- Families are subjected to enormous economic stress attributed to several factors: the increase in poverty over the last decade; the lack of low income housing; the lack of employment opportunities for less skilled workers, which particularly affects single mothers; the low minimum wage that, in most communities, is not a living wage; and, the lack of medical insurance and fringe benefits for many workers.

- There is far more substance abuse in families, both alcohol and drug abuse, but primarily alcohol.

- There is more physical and psychological violence in families. Many youth workers believe that there is a corresponding increase in violence among youth on the street that is partially a result of the violence youth have been subjected to at home.

- There is far more physical and sexual abuse in families. Programs report as much as 50 to 80% increases in the last five years in the numbers of youth reporting abuse. Some of the increase may be due to the fact that there is less stigma and more awareness among youth about reporting abuse. None of the programs, however, attributes all of the increase to more accurate reporting. In fact, many youth workers suspect that there is still under-reporting of abuse since many youth will not discuss abuse until a trusting relationship has developed, which may take months or years.

- Youth workers also are convinced that more parents today (perhaps because of severe economic stress) have abrogated parental responsibility and are not providing emotional support and stability to their children. Runaway and homeless youth display the effects of emotional deprivation, and are seriously depressed and angry, which results in more bizarre, violent forms of behavior.

In her review of the recent literature on homeless youth, Robertson (1989) corroborates much of what we heard on our site visits with respect to family problems. In particular, her study confirms that there is a strong correlation between physical and sexual abuse, as well as parental substance abuse, and homelessness in adolescence.

Program staff find themselves struggling to resolve competing imperatives with respect to the families of the youth they serve. All of the programs funded by the Runaway and Homeless Youth Act (and most youth workers) continue to subscribe to family reunification as their ultimate goal, despite the profound erosion in the stability and structure of the families of runaway and homeless youth. Many of the youth workers we interviewed, however, are convinced that reunification is becoming increasingly difficult—if not impossible—to achieve. They contend that *reconciliation,* rather than reunification, is not only a more realistic goal, it is also the most beneficial outcome for many of today's street youth, particularly those over the age of 16.

Youth workers cite a number of factors which hinder reunification efforts (and discourage some programs from even attempting reunification). These include: the severity of family problems, which necessitates long-term family therapy conducted by specially trained therapists; the lack of resources for long-term family work and the shortage of and difficulty in recruiting appropriately trained staff; the inability or unwillingness of severely stressed parents to participate in intensive therapy and to make the difficult changes often required for reunification; the long distances that separate out-of-state (or undocumented) youth from their families, making it impractical to work with families; the length of time some youth have spent on the street prior to seeking help; and, finally, the belief that family reunification may pose a real danger to some youth because of intractable violence and abuse in the home.

Proponents of family reunification believe that these barriers can be surmounted if adequate staff and resources are invested in family preservation. They point to high success rates when services (particularly in-home services) are available both at the time of intake and on a long-term basis to circumvent the assumption that reunification efforts are doomed to fail. Program directors at many of the projects we visited, however, expressed concern about the lack of funding for family preservation services and the need for training on-board staff to work with today's families. The staff we interviewed do not wish to ignore a youth's relationship with family since it is well-documented that some resolution of family issues is critical to exiting street life (Boyer, 1988). However, they also recognize that even with highly trained staff, resolution of family issues can be a lengthy process; in the meantime, youth need a safe, stable place to live. Should limited program resources be expended for hiring and training staff to work with families

or for developing housing options for youth? For which youth? Under what circumstances? These are difficult policy issues which are compounded by still other changes in the nature of the population.

THROWAWAY YOUTH

Many of the youth we interviewed did not leave home by choice. Some left home to escape physically or psychologically abusive adults. Others were pushed out by parents who had run out of patience or money. Others left to escape alcohol or drug related violence. Others were put out when a family was forced to live in a shelter that did not accept teenagers or because the family had to "double-up" with relatives who had room for only the youngest children.

In every city we visited, program staff and community agencies reported an alarming increase in the number of "throwaway kids", that is, youth who have not "chosen" to leave home. In San Diego, for example, an officer from the police department's Juvenile Administration offered these speculations as to why there are more throwaway youth in his city:

- Rental prices and housing costs have risen so drastically that parents must work longer hours just to pay the rent, leaving children—particularly teenagers—unattended; or, families must live in such cramped quarters that teenagers are forced to move out;

- Lack of low-income housing requires families to spend over two-thirds of their disposable income on rent, often causing families to double-up or become homeless; the resulting stress on parents contributes to family violence, alcohol and drug abuse;

- A dramatic increase in gang activity (gang membership in San Diego has doubled in the past four years from 1,500 to 3,000) has further eroded family ties by alienating teens from their families; and,

- The easy availability of cheap, highly addictive drugs, such as crack cocaine and crystal methamphetamine, is eroding family structures at a time when treatment interventions are severely limited.

Robertson, too, notes the growing phenomenon of throwaway youth and cites a Hollywood, California sample in which nearly one-third of the youth reported that they were told to leave their last dwelling (Robertson, 1989).

Among the population of throwaway youth, staff at some programs report an increasing number of gay and lesbian youth who have been rejected by their families because of their sexual preference.

Many homeless youth have cycled in and out of their own home or foster care repeatedly until, finally, both the youth and the system have given up. For these older youth, neither family reunification nor system placements are viable options. The programs we visited, such as the Storefront in San Diego, which serves a large number of undocumented youth, and Bridge in Boston and Neon Street in Chicago, which serve many older homeless adolescents, report that at least half of their clients have no realistic hope of returning home. In Los Angeles County, Rothman reports that only 19% of shelter clients were "good candidates" for family reunification (Rothman, 1985).

SYSTEM FAILURES

Throwaway youth are not only adolescents who have been evicted by their families, but, increasingly, in the last decade, adolescents who have been rejected or ejected by public social service systems as well. Every program cited an increase in so-called "system failures", i.e., youth who are pushed out of foster care, group homes, residential treatment facilities and psychiatric inpatient facilities, without aftercare plans; or youth who are not accepted by child welfare or child mental health systems in the first place because these public systems are overwhelmed, do not have appropriate services available or refuse to deal with difficult older youth or youth who do not have the "right" label or diagnosis.

In most of the cities we visited, child protective services are so swamped with younger children and resistant to serving older youth that they have unwritten policies not to accept youth

over the age of 12. In every city, appropriate adolescent mental health and substance abuse programs are severely limited and often accessible only to insured youth.

YouthCare in Seattle reports that nearly 50% of the youth with whom it comes into contact are "system failures". In Boston we learned of an informal survey that found nearly half of older adolescents in adult shelters for the homeless to be former "system kids". YDI in Albuquerque cites the 70% school drop-out rate of homeless youth as evidence that the education system is failing multi-problem youth. Robertson (1989) reports that over 40% of the Hollywood "street" sample had been in foster care, nearly 40% in group homes, over 55% in juvenile detention, and nearly 25% hospitalized for psychiatric problems.

The erosion in the capacity of traditional institutions—families, schools, human service systems—over the last decade has had enormous implications for programs serving runaway and homeless youth. At its most fundamental level, it has limited the options for providers. Where is a 16-year-old to go if he cannot return home or be placed with a child welfare agency? What if he has a psychiatric or substance abuse problem and there are no day treatment or residential treatment programs available? What if the 16-year-old is a female who is pregnant, and the child welfare system will take the baby but not the mother?

OLDER AND YOUNGER

Programs report that runaway and homeless youth today are both older and younger. In the first instance, there are many more 18- to 24-year-old homeless adolescents than a decade ago. These youth may have "aged out" of a system placement, such as foster care, with no follow-up plan or independent living skills. They may be runaway youth who have been living on the street for a number of years. They may be youth whose families are homeless.

In the second instance, programs report they are seeing many more chronic, "streetier", younger runaways, as young as 10 to 11 years old, who have already been on the street for a year or more. In both instances, these are different populations, with different service needs, than the

first-time runaway envisioned in the 1970s, who, as noted in Chapter III, comprises an ever-diminishing proportion of the service population.

While short-term crisis intervention and emergency shelter may be sufficient for some youth, many younger chronic runaways and older homeless adolescents may also require: long-term counseling—not just crisis intervention; long-term housing options—not just 15-day emergency shelter; alternative education; employment training; and, frequently, substance abuse treatment, intensive mental health services and health care services as well. This is a far more comprehensive and demanding array of services than was initially envisioned by the Runaway and Homeless Youth Act. Although a 1988 amendment to the Act authorized grants for transitional or independent living programs, funding falls short of the need.

MORE HOMELESS YOUTH

Programs report that caseloads today are made up of many more youth who are, quite literally, homeless. They include: chronic street youth who have been away from home a year or more and for whom reunification is unlikely; throwaway youth; youth who have fled abusive, dangerous home situations; system youth who have been rejected or ejected by traditional agencies; and, many more older, 18- to 24-year-old homeless adolescents.

Again, while some youth may only need emergency shelter, along with family preservation services, truly homeless youth require a continuum of housing options, with support services, that extend well beyond 15-day emergency shelter. They also need an alternative to adult homeless shelters, which, in the past few years, have been admitting more adolescents, a fact that is causing considerable concern among youth services providers who fear that adult shelters unintentionally "enable" youth to continue living on the street.

MORE FEMALES

Many of the programs we visited reported that the number of female *runaways* has increased in the last 10 years, to the point that they now out-number males. (This is not the case

among older, *homeless* adolescents, however, who tend to be males.) Youth workers speculate that females may seek help more readily than males and, thus, make it appear there are more female runaways. Robertson (1989) notes that, while programs report more females, street samples would seem to indicate more males.[3]

MORE PREGNANCY

Perhaps consistent with the fact there are more females seeking shelter, programs at every site reported more pregnant females, as well as more youth having second babies. Increased pregnancy rates may be related to increased drug involvement (see below), which lowers inhibitions, making the use of contraception less likely. It may also be related to increased prostitution (i.e., survival sex) among females, which several programs reported. Another contributing factor may be the failure of state child welfare agencies (which formerly had responsibility for these youth) to provide either independent living skills, family planning or safe sex information. A 1987 study of state child welfare agencies, for example, found that only two had comprehensive policies for meeting the sexual development and family planning needs of youth in foster care (Polit, et al., 1987).

Research corroborates that pregnant homeless teens are at high risk for low birthweight babies and high rates of infant mortality because they often do not have access to prenatal care and may be drug- or alcohol-involved (Sullivan and Damrosch, 1987; Robertson, 1989). Of the sites we surveyed, only Bridge in Boston has developed housing with support services specifically for pregnant runaway and homeless teens and teen mothers and their babies. Several other programs are considering this component, however, particularly in those cities that are experiencing severe cutbacks in social services spending.

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[3]Street samples, on the other hand, may understate the number of females since females are more likely to be "housed" by pimps or to stay in crack houses.

MORE MINORITY YOUTH

Programs that had been serving predominantly white youth a decade ago report that they are serving more minority youth today and seeing more minority youth living on the street. Programs speculate that the increase in minorities may be due to several factors. A major factor is the role demographics play. Minority youth are a growing proportion of the overall youth population, particularly in large urban centers (Wetzel, 1987). Additionally, minority youth, including immigrant youth, are at greater risk for poverty and homelessness. Minority youth also are greatly over-represented in state child welfare, juvenile justice and mental health systems, which, as noted earlier, are not adequately preparing youth for independent living.

The increase in minority youth poses new challenges to providers who had not served large numbers of minorities in the past. Programs report an inadequate number of minority staff or staff trained in cultural competencies. They also report that specialized services in the community, such as substance abuse and psychiatric services, while in short supply or inappropriate for all adolescents, are particularly inadequate for minority youth.

SCHOOL FAILURE

At every site we visited, youth workers described teens with long histories of school failure, repeated suspensions and grade repetitions. Many youth indicate that their decision to leave school was a principal cause of the family conflict that led to their leaving home. On the other hand, many observers suspect that family conflict is a major cause of academic failure. There is little doubt, however, that the combination of family instability (clearly on the increase in the last decade) and academic failure is a powerful propellant to leaving home.

Two regional surveys done in the 1980s revealed extremely high rates of school failure among homeless youth. The 1989 Hollywood street sample of homeless youth cited by Robertson (1989) found that over one-quarter of those questioned had been held back a grade at least once; one-quarter reported participation in special education classes or remedial reading and math classes. A 1984 New York City study found that 55% of the boys and 47% of the girls had

repeated a grade; and, 77% of the boys and 44% of the girls had been suspended or expelled, mostly for fighting or drug use (Shaffer and Caton, 1984).

High rates of academic failure such as these have increased the pressure on service providers to create their own school programs or to encourage the local school system to adopt an innovative curriculum for high-risk youth.

AIDS

Obviously, AIDS was not an issue with which runaway and homeless youth programs had to contend in the 1970s. Practitioners and researchers both agree that today's runaway and homeless youth are at high risk of HIV infection because they engage in high-risk behaviors, specifically, unsafe sex practices and drug use (Woodruff, et al., 1989; Robertson, 1989).

All of the programs are now engaged in AIDS prevention and education activities (see Chapter IV). Staff report that these activities are having mixed results on changing awareness and behaviors. Specifically, workers reported that male youth, particularly minority youth, are increasingly aware of the danger of AIDS, which they realize is not just a threat to gay, white men. Staff also reported a decrease in male prostitution, which they suspect is due to a decline in demand caused by the threat of AIDS. On the other hand, most programs reported a disturbing increase in the number of younger boys on the street who are engaging in survival sex.

The picture seems to be even less clear with respect to female prostitution and AIDS awareness. Staff believe that females are less knowledgeable about AIDS, and they are uncertain whether female prostitution has decreased or increased. While there seem to be fewer females in recent years soliciting on the street, it is assumed there is more off-the-street prostitution today through pimps, motels and crack houses.

SUBSTANCE ABUSE

Substance abuse rates among runaway and homeless youth consistently have been reported to be higher than among youth in the general population (Miller, et al., 1980). There was no agreement among the youth workers we interviewed as to whether rates have increased over the past decade. In some areas, experts are convinced that substance abuse has increased; others contend that what has changed are the types of substances used and the environment in which they are used.

In all the cities we visited, however, youth workers agreed about the following changes with respect to substance abuse:

- Youth on the street are using drugs and alcohol at younger ages than a decade ago;
- There is more involvement in drug trafficking (some theorize that youth have turned to selling drugs as the demand for selling sex has fallen due to AIDS);
- There is far more drug-related violence on the streets;
- The drugs that are available today are more highly addictive, more readily accessible and more volatile;
- Youth are more heavily engaged in poly-substance use;
- Alcohol is the most abused substance; drugs of choice vary by city and, often, by sub-culture within a given city; and,
- Many runaway and homeless youth use drugs and alcohol as a form of self-medication and sell drugs to survive on the street.

As one agency director told us: "Whether it is the volatility of today's drugs, like crack, drug-related violence on the streets, more kids' dealing drugs or kids' using at younger ages, the 'noise level' with respect to substance abuse is way up over a decade ago."

This heightened "noise level" has put new pressures on providers. Virtually all of the programs have found few appropriate substance abuse treatment programs available in their

communities; yet, most are reluctant to develop in-house treatment components, recognizing that these are highly specialized, expensive services to provide.

MORE EMOTIONAL DISTURBANCE

Along with substance abuse, all of the programs reported significant changes in the mental health status of runaway and homeless youth today. Programs report an influx of youth with serious emotional problems, and many more with dual diagnoses of emotional disturbance and substance abuse. As one counselor told us: "We are seeing far more damaged kids, more suicidal, more borderline personalities, unstable, fragmented psyches which, combined with substance abuse, creates more bizarre kinds of behaviors." There is greater depression and stress among youth today, which increases the likelihood of risk-taking behaviors, such as substance abuse and unsafe sex.

Many providers recognize that youth with serious emotional disorders may need more structure, and certainly more specialized clinical expertise, than runaway and homeless youth programs typically provide. As with substance abuse treatment, however, appropriate mental health services for adolescents are not available in most of the communities we visited, confronting programs with the dilemma of deciding whether to develop in-house expertise in mental health treatment.

GANGS

Virtually all of the programs reported increased gang activity and gang involvement among runaway and homeless youth over the past decade. This is true even in communities, such as Chicago, where law enforcement efforts have not decreased or have actually intensified.[4] In some cities, such as Albuquerque where there are reportedly 44 different gangs, there is so much competition for gang members that gangs are soliciting from ever younger age groups and from different sub-cultures that traditionally had been excluded. Programs report not only that there

[4]Some programs complain that their cities are unwilling to acknowledge the seriousness of their gang problems and that this "head in the sand" attitude has allowed gang activity to flourish.

are more gangs, but that gangs are more violent, more money-oriented, have more weapons and are more involved in bizarre cult behaviors, such as satanic worship.

While there are some notable exceptions, such as Youth Development, Inc. in Albuquerque and San Diego Youth and Community Services, most runaway and homeless youth programs have not been involved historically in gang intervention work. The increase in gang activity in recent years is another factor placing new demands on providers.

MORE VIOLENCE

Program staff report far more violence on the streets, more guns and knives, and more violence among youth toward one another, than a decade ago. Some of this increased violence is an outgrowth of the surge in drug and gang activity, but much of it youth workers attribute to the violent, chaotic family environments from which many youth come, bringing with them histories (and learned behaviors) of physical and sexual abuse. Staff are seeing more youth who are violent offenders and sexual offenders as well. Staff say there is a deeper sense of hopelessness among today's youth, particularly among young African American males, who have little orientation to the future, opening the way for more thrill-seeking, callous and, inevitably, violent behaviors.

Increased violence has made program staff more security conscious. More problematic, it has made the work of outreach and intervention far more difficult.

* * * * * * *

In summary, several overriding points can be made about changes in the nature of the service environment today that have been precipitated by changes in the nature of the population:

- As the problems of youth have become more complex, programs are having to become more comprehensive, either by adding in-house components or developing partnerships with other agencies (or, typically, a combination of both).

- Programs must engage in extensive networking with other agencies because there are many more agencies which have sprung up in response to new

problems and populations. For example, in almost every community there is a coalition of AIDS prevention, education and treatment providers that did not exist a decade ago. There are many more homeless adult and family shelter providers with whom relationships must be established. "New morbidity" problems, such as AIDS, adolescent pregnancy, drug abuse and street violence, necessitate collaboration with various health care providers, substance abuse and mental health treatment programs—where they exist.

- Staff of runaway and homeless youth programs need, not only the skills they traditionally have had, but highly specialized skills in such areas as substance abuse, mental health and housing.

- Programs must rely on increasingly diverse funding sources to meet multiple service needs and to offset cuts in social services spending over the last decade. This demands more sophisticated and time-consuming fundraising, accounting, reporting and fiscal management than a decade ago.

The history of any one of the programs we visited that has been in existence since passage of the Runaway and Homeless Youth Act in 1974 illustrates the way programs have evolved in the last two decades. **YouthCare** in Seattle provides our example here.

The original program of YouthCare was The Shelter, a 15-day emergency shelter program for runaway youth, which opened in 1974 with funds from the Runaway and Homeless Youth Act. In 1979, The Shelter added a street outreach component funded initially by United Way and, subsequently, by the Federal Office of Juvenile Justice and Delinquency Prevention.

In 1981, recognizing that the outreach team could provide only limited services, The Shelter applied for a national demonstration grant from Act Together (a unique collaborative effort between the federal government and a private foundation) to develop more comprehensive services. By developing partnerships with other agencies, particularly in the areas of employment training and education, The Shelter hoped to expand its services. The Shelter staff discovered, however, that it was difficult to get youth to go to other agencies unless they were accompanied by The Shelter staff, which often was not practical.

In an effort to overcome the problem created by decentralized services, The Shelter, in partnership with seven other agencies, developed the Orion Center, a drop-in center with in-house services, in 1984. All at one site, Orion Center offers alternative education classes provided by Seattle Public Schools, a health clinic staffed by the University of Washington, meals provided by volunteer church groups and counseling provided by The Shelter staff. This collaborative arrangement was administered with a fairly loose management structure. As lines of authority became confusing, The Shelter again restructured and, in 1985, changed its name to Seattle Youth and Community Services, which became the umbrella agency for the 15-day emergency shelter, the street outreach component

and Orion Center. Each of the collaborating agencies entered into specific subcontracts with Seattle Youth and Community Services.

In 1986, Seattle Youth and Community Services added its first longer term (i.e., transitional) housing component for female runaway and homeless teens, ages 16 to 18, involved in or at high risk for prostitution. In 1988, it added an AIDS prevention, education and outreach component and a substance abuse counselor. In 1989, it began a gang intervention project and opened its second longer term housing component for older homeless adolescents, ages 18 to 21. Currently the agency is collaborating with the State Department of Mental Health to develop an intensive case management program, based on a mental health model, for runaway and homeless youth with serious emotional problems. It has also changed its name to YouthCare, which it hopes will become a more easily recognizable name in the community.

Administratively, YouthCare has gone from being a fairly small program in which the executive director was expected to handle everything from fundraising to program development, to a comprehensive, multi-funded agency with a management team that has specialized functions, including a clinical director and a full-time fundraiser. In 1974, YouthCare engaged in very little formal collaboration with other agencies. Today it has formal agreements with at least eight major agencies and informal arrangements with many more. YouthCare's Board in 1974 was comprised primarily of other service providers and advocates. Today the Board is augmenting its capacities by including members with specialized expertise in areas such as fundraising, housing, research and evaluation.

CHAPTER III.

RUNAWAY AND HOMELESS YOUTH: A DESCRIPTION OF WHO IS BEING SERVED

Both researchers and practitioners have difficulty defining and counting runaway and homeless youth (Boyer, 1988; Robertson, 1989). National estimates of the *number* of runaway and homeless youth, which range between 730,000 and 1.3 million, are based largely on youth who seek shelter and only include youth up to age 18 (Janus, et al., 1987). This leaves at least two groups uncounted: older homeless adolescents, ages 18 to 24; and, street youth who never come into contact with programs. The lack of consensus on a *definition* of runaway and homeless youth reflects, in large measure, the diversity of this population and the fact that it is neither static nor homogeneous throughout the country.

Determining the number of homeless and runaway youth is complicated by the lack of a consensus on the definition of "runaway" and "homeless". The federal government, for example, defines a *homeless* youth as a person younger than 18 who is without a place of shelter where he or she can receive adequate care. Many of the programs we visited, however, include older youth, ages 18 to 24, in this category of homeless youth. Most youth workers define *runaway* teens, in contrast to those they call homeless, as youth who are temporarily estranged from a family (it may be a biological or foster family) or from an institution (such as a group home or residential treatment center). Many youth workers identify sub-groups of runaway youth, including: "baby runners" who are young, first-time runaways; "chronic runaways" who have been on the street at least several months; and "street flirters" who repeatedly leave home for short periods. According to the National Network of Runaway and Youth Services, "pushouts" or "throwaways" are youth who have been "forced out of their homes with the approval of their legal guardian" (Hughes, 1989).

Since the constellation of youth differs in each community we visited, it is not surprising that each of the seven programs in this report attributes different characteristics and age limits to their interpretation of the terms homeless and runaway. In fact, runaway and homeless youth defy any single definition. They may range in age from very young, frightened and fragile 12-year-olds to street-hardened 20-year-olds. They may have been on the streets for two days or several years. They may be victims of sexual, physical or psychological abuse. They may be in search of excitement or seeking a new identity and a new "family". They may be unwanted, neglected "throwaways". They may suffer from serious mental illness, or drug dependency. They may be pregnant, they may be parents, or they may have AIDS. They may be gay or lesbian youth. They may engage in "survival sex", or pornography. They may steal to survive or to support a drug habit. Many have dropped out of school before gaining the minimal skills necessary for employment. Some have places to live—dangerous places where they are exploited or mistreated—and some have homes to which they can return. There are those who want to return home; those who have no homes; those who refuse to return home; those who are forced to leave home; and, those who do not know what they want to do or where they want to go. Some homeless youth are illegal aliens, a disproportionate number are minorities, and most are deeply distrustful of any attempts at intervention.

This section attempts neither to define nor count runaway and homeless youth. Rather, it describes the populations of runaway and homeless youth being served in the programs we visited and the number being served as estimated by each program. This description and count does not include homeless youth who are <u>not</u> being served in the seven cities visited. Nationally, it is estimated that over half a million youth on the street are not served (Boyer, 1988), so a sizeable piece of the picture is missing.

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Boston

Bridge Over Troubled Waters in Boston makes a clear distinction between its "runaway" and "homeless" youth populations. Currently, Bridge is serving many more homeless youth than 10 to 15 years ago when runaway teens dominated caseloads.

Bridge describes its predominant population as homeless adolescents, typically, 18- to 24-year-old males, who are more street-wise than runaway youth and have more serious mental health and substance abuse problems. Unlike the younger runaways, these teens and young adults are, literally, homeless in that they have neither family nor the traditional service systems, such as child welfare, that are able or willing to provide them with a place to live. Bridge's 1989 statistics indicate that although nearly two-thirds of the runaway youth it served remained at home, returned home or received a Department of Social Services placement, fewer than 23% of the homeless adolescents it served returned home or were eligible for foster care; most, 60%, remained homeless.

Bridge describes its smaller population of runaway youth as, typically, white females, age 16, who are originally from within a 50-mile radius of Boston and are first-time runners fleeing an abusive home situation. Bridge staff report that this population is declining as a percentage of Bridge's overall caseload; the major service pressures the program faces today come from older homeless adolescents and young adults.

"Typical" profiles do not convey the diversity of sub-populations that Bridge serves. A more complete picture is conveyed by looking at the groups of youth with whom Bridge comes into contact through its street outreach. These include:

- In Harvard Square in Cambridge, the population is predominantly younger teens, about evenly split between males and females, composed of punks, rockers and groupies, mainly white, not involved in prostitution, and difficult to engage because of a closed sub-culture that is very distrustful of adult intervention;

- In Park Square in downtown Boston, the population is predominantly comprised of older male hustlers, involved in prostitution, mainly white but

with an increasing number of African Americans, who are more likely to be involved in substance abuse and have histories of sexual abuse; and,

- In the downtown area, called the "Combat Zone", and at its drop-in center, Bridge is serving more of a population that it calls "community kids"—i.e., many more poor African American youth from nearby Roxbury who, like the second generation Irish and Italian youth from impoverished neighborhoods in South Boston and the North End that Bridge has always served, are "throwaway" youth (that is, have been kicked out of their homes), or are fleeing abusive home situations (often related to parental alcohol or drug abuse).

Each of the sub-groups that Bridge serves has among its members gay and lesbian youth, teen parents, HIV-infected youth and many more "system kids", that is, youth who have formerly been involved with the child welfare, juvenile justice and mental health systems, and who bring with them complex additional service needs. For the most part, Bridge does not serve gang members.

In 1989, Bridge served about 2,300 individual youth[5], about 65% of whom were older homeless adolescents and the remaining 35%, younger runaways. Most of its population is from the Greater Boston area. Bridge youth come from diverse economic backgrounds. The program is serving more minority youth than 10 to 15 years ago (now about 54% of its total population), and more female runaways; however, the major increase is among older homeless youth, most of whom are male.

Seattle

YouthCare in Seattle does not make as fine a distinction between runaway and homeless youth as Bridge does, and, in contrast to Bridge, YouthCare still focuses predominantly on youth under age 18. However, the under-age-18 population YouthCare serves is more literally homeless, without family or "system" options, than runaway youth of 10 to 15 years ago, and, like Bridge, the program reports far fewer, first-time "baby" runaways within its overall caseload. Also, YouthCare

[5]This figure does not include an estimated 3,000 street outreach contacts (not individuals).

is experiencing increasing pressure to serve older, homeless adolescents, ages 18 to 24; as yet, board and staff are ambivalent about whether to embark on this expansion.

Although YouthCare is serving fewer first-time runaways, ironically, the age of the street youth it is serving has been going down. (Also, the age at which youth begin to prostitute is going down; the average age of entry is now 15.) Staff explain that first-time runners are starting to leave home at younger ages, many at 9 and 10 years old. When these adolescents show up at YouthCare, having been in and out of street life for some time, they are no longer "baby runaways", although they still may be only 12 or 13 years old.

YouthCare specializes in serving street youth, including juvenile prostitutes, male and female. It also has a major focus on outreach to the juvenile justice system, particularly to youth detained on charges of soliciting. The diversity of youth served by YouthCare is reflected in the populations that its outreach workers contact. These include:

- In Seattle's University District (similar to Boston's Harvard Square area), a majority of the youth are rockers, punks and other new wave sub-cultures, mainly white, about evenly mixed male and female;
- In the downtown area, there is a racially mixed population that includes a sizeable number of young male prostitutes and intravenous drug users;
- In Seattle's Broadway area, where youth who identify themselves as skinheads and punks predominate, the population is mainly white and, in many respects, similar to the University District, but encompasses a wider age range, including more 18- to 24-year-olds.
- The Highway 99 strip is predominantly young female prostitutes and is racially mixed; and,
- Rainier Valley includes mainly "community kids", that is, African American youth from the Rainier Valley area.

As with the populations served by Bridge, a number of sub-populations cut across all of the groups described above; these include teen parents and pregnant teens, gay and lesbian youth and "system kids". YouthCare also has just begun to work with gang members.

YouthCare served about 1,200 individuals in 1989[8], the vast majority of whom were under age 18 (the average age of YouthCare's population is 16). Most of the youth are from economically diverse neighborhoods in the Seattle and King County area. YouthCare is serving more minority youth (now about 40% of its population) than 10 to 15 years ago.

A profile offered by YouthCare's mental health consultant is illustrative, not only of Seattle's youth, but of runaway and homeless youth in each of the other cities as well:

> These are kids who have poor judgment, poor impulse control, lack of insight. There is a greater sense of hopelessness among these kids (than with youth a decade ago), which leads them to engage in more thrill-seeking and callous behaviors without boundaries. Most have dual diagnoses of emotional disturbance and substance abuse, and many are using drugs as a form of self-medication. You find among these kids more borderline, fragmented personalities, histrionic, narcissistic—kids suffering from major depressions and post-traumatic stress disorders. These are kids who have endured a great deal of emotional violence and deprivation and, as a consequence, they are very angry kids.

Chicago

Neon Street Center for Youth on Chicago's North Side serves both runaway and homeless adolescents, but 85% of its current population are 18- to 21-year-old homeless youth, rather than younger runaways. In fact, Neon Street was founded by a task force of adult shelter providers, as an alternative to adult shelters for older homeless youth, who do not have family or "systems" options.

Neon Street served about 500 youth in 1989 (its third year of existence), which was a 40% increase over the previous year. About half of Neon Street's population is made up of "community kids" from the Chicago area, who are African American and economically disadvantaged; many are "throwaways" from their family of origin or from the social service system. The other half, who come from out of state or outside Chicago, are mainly white and represent a diversity of economic backgrounds. Neon Street is developing an expertise in working with

[8]This figure does not include an estimated 3,000 street outreach contacts.

young African American males involved in prostitution. At present, its population, which is slightly more male than female, also includes gay and lesbian youth and pregnant teens. Neon Street serves very few gang members.

Albuquerque

Youth Development, Inc. (YDI), located in Albuquerque's South Valley, serves predominantly disadvantaged Hispanic adolescents from the barrios and their families. However, since it began two years ago to include pre-school age children in its gang and substance abuse prevention outreach and adult IV drug users in its AIDS outreach work, YDI now spans the broadest age range of any program we visited. Increasingly, YDI is targeting neighborhoods, rather than discrete populations of youth. Their focus is on poor, drug and gang ridden neighborhoods, involving the entire community as a means to reach youth.

YDI began targeting pre-school and elementary-age children when it became apparent that gangs and drugs had begun to take hold at younger and younger ages. The average age for the onset of alcohol abuse in New Mexico is nine; in addition, the large numbers of gangs in the Albuquerque area—believed to be 44 different gangs—are vying for recruits at ever younger ages.

The majority of YDI's client population, however, are youth, ages 12 to 21. Most are "community kids" from targeted Albuquerque neighborhoods—from the predominantly poor, Hispanic South Valley; the poor, African American South Broadway area; and, the more racially and economically diverse North Valley. Most are not runaways but throwaway or homeless youth. However, YDI also does serve a small number of runaway youth, some from other cities and states, most of whom are white and many of whom are "system kids". YDI youth include pregnant teens and teen parents, gang members, and system youth, particularly those who have been involved with the juvenile justice system.

YDI served about 1,300 youth in 1989, not counting several thousand youth with whom it came into contact through its various outreach components. Most were between the ages of 15 and 19, equally divided between male and female and about two-thirds Hispanic.

San Diego

San Diego Youth and Community Services' (SDYCS) emergency shelter, *The Storefront,* has a mandate from the State of California to assist juvenile prostitutes and other adolescents to leave the streets permanently. In 1989, The Storefront sheltered 550 chronic homeless and runaway youth between the ages of 12 and 18 and contacted another 1,500 youth through its outreach van. Twice as many males as females came through intake; although males continue to predominate, staff report a distressing influx of young runaway girls, between the ages of 12 and 14, who are seeking shelter.

The Storefront does not make an absolute distinction between homeless and runaway youth. Staff believe that some youth who consider themselves homeless may be able to return home if an opportunity is provided for effective family therapy and reconciliation. However, The Storefront also serves a population of undocumented aliens, almost all of whom are Latinos, who are undeniably homeless. Unlike the Hispanic adolescents at YDI in Albuquerque, many Latinos at The Storefront speak little or no English and have no community that claim them; the alienation of San Diego's undocumented teens renders them particularly vulnerable to the lure of gangs, prostitution and drug dealing.

Over 40% of The Storefront's population are either Asian, African American or Latino. This large component of minority youth come from more impoverished families than their white counterparts. In addition, many of the Asian and Latino youth suffer from severe cultural alienation, which is exacerbated by their unfamiliarity with English. The Latino youth who are undocumented have the added fear of being apprehended. In other respects, minority and white youth share common problems. Almost all are abusing drugs and alcohol; 53% engage in "survival sex"; a large number of the females are pregnant; over 60% have been physically or sexually abused (staff suspect that this figure is low since youth tend to "cover up" their parents' abuse); and, many have been ejected from home because of their gay or lesbian orientation.

SDYCS also runs two shelters for runaway youth at risk of homelessness—the *Bridge* and the *Gatehouse.* These programs enroll a population that is not yet living on the street, but who have experienced serious family disruption; have been arrested for shop-lifting, prostituting or

drug-related crimes; or, have been removed from a foster home, group home or residential treatment facility. Young, vulnerable adolescents who seek admission to The Storefront are often referred immediately to one of these shelters, as a means of protection as well as treatment.

Most of the youth in these shelters come from poor or near-poor families with histories of drug and alcohol abuse that span at least two generations. Other than the fact that the shelter residents are typically so-called "system failures", rather than street-wise youth, the programs serve populations similar to the Storefront population, i.e., troubled adolescents from disorganized, severely stressed families. However, unlike youth at The Storefront, 30% of whom come from other states, almost all Bridge and Gatehouse youth are residents of San Diego County.

Des Moines

The Iowa Homeless Youth Center (IHYC) serves "hard-core" street youth through its outreach van and "system failures" through its residential components. Although IHYC residents, who range in age from 16 to 24, come from homes characterized by abuse, neglect and severe stress, they are not homeless. Most youth live at IHYC with the permission of a parent or guardian who know of their whereabouts and may choose to participate in family counseling. Telephone calls and weekend visits "home" are not unusual occurrences for IHYC residents.

Veterans of the child welfare or juvenile justice system, these youth typically apply for admission to IHYC at the suggestion of a parole officer, lawyer or social worker. Most IHYC teens have been in numerous placements, such as foster families, group homes and residential treatment facilities. Once they reach age 15 or 16 and "the system" no longer has any resources to offer them, they are left to fend for themselves or returned to families that do not want them.

None of the IHYC's residents has lived on the streets for more than a few days. Rather, after leaving home (or being forced to leave home), most found temporary residence with a friend, a relative, the family of a friend, or at an emergency shelter. Coming to the IHYC prevented them from having to resort to the street. Physical and sexual abuse are common complaints. "These

are kids with 'drop-out parents', who just don't want to be bothered anymore" was the way one staff member described the typical IHYC youth.

The Iowa Homeless Youth Center's outreach van serves a vastly different population, comprised of "hard-core" street youth, most of whom have been living on the run and on the street for more than two years. Truly homeless, these youth regularly engage in survival sex, drug dealing and prostitution. This street population is composed of older adolescents, between 14 and 22 years of age, many of whom come to Des Moines from other cities. Predominantly white, but with some minority group members, these youth hang out in the downtown "loop", in shopping centers or city parks, often finding temporary shelter in the boarded up houses and apartments that scar the city.

Although there is a growing gang population—and increased violence—in downtown Des Moines, particularly among the Crips and the Bloods, two California gangs who exported members to the Midwest several years ago to expand their drug market, IHYC's outreach team does not attempt to contact gang youth. An amicable agreement has evolved between IHYC and two other youth-serving agencies that specialize in gang work, assigning specific territories to each agency.

Iowa City

United Action for Youth (UAY) is the only program of the seven we visited which does not focus its services solely on high-risk youth. All young people between the ages of 12 and 18 are encouraged to participate in UAY's activities. However, in 1989, about 85% of UAY's 650 clients were "troubled youth" who came to UAY's Youth Center to participate in family or individual counseling, detention diversion counseling or abused victims' services. To increase self-esteem and foster new interests, however, UAY's "troubled youth" are also encouraged to participate in the center's arts and recreation program, which draw many youth who are not at risk.

Although one-fourth of the teens who participate in the Youth Center's arts and recreation programs are functioning well both at home and at school, they often voluntarily join

support groups and participate in peer counseling or rap groups that bring them into close contact with more troubled youth. This mix of adolescents who are high functioning with those at high risk is a unique feature of UAY's program.

Only 10 to 20% of the 650 adolescents who use UAY's services annually are runaway or homeless youth. Most youth come from Iowa City, but some hitchhike to town on the nearby interstate highway. Eighty-five percent white, they come to Iowa City from rural areas in search of work, health care (Iowa City has a free clinic) or a University of Iowa student (often a friend of a friend) who will give them a place to "crash". They are also attracted to Iowa City because the state's only indigent care hospital is located there.

UAY staff are convinced that the increase in poverty, which in Iowa has been exacerbated by farm foreclosures, is the principal cause for much of the family disintegration, alcoholism, abuse, and depression that characterize the families of UAY's youth. In 1989, over half of all troubled youth served at the center came from families whose incomes were below the poverty line.

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In addition to describing whom the seven programs serve, it is also informative to look at whom they do <u>not</u> serve. Virtually all the programs exclude the following populations (although most programs make a concerted effort to refer such youth to more appropriate services):

- Youth with mental retardation or youth with serious developmental delays who are considered too vulnerable for an unprotected setting;
- Youth with serious emotional disturbance who pose a danger to self or others;
- Violent or predatory sexual offenders; and,
- Youth who are so high on alcohol or drugs that they require detoxification services before being able to participate in the program.

CHAPTER IV.

ESSENTIAL SERVICES: ISSUES AND STRATEGIES

OVERVIEW

This chapter focuses on major service components critical to addressing the multiple needs of runaway and homeless youth. For purposes of clarity, it is more "component-oriented" than is the case with effective programs. Good programs blur the boundaries between service components to create a seamless network of services that youth may move into and out of as their needs change.

Effective programs minimize service fragmentation (a major failing in traditional, categorical services) in a number of ways. Communication among staff across components is key. Information sharing is not left to happen. It is made to happen. Regular meetings are held. Program data are widely shared. Most importantly, there is regular communication among direct service staff. Twenty-four hour staff in residential and crisis components, for example, maintain written logs so that each shift is kept apprised of important information.

In successful programs, no matter how large the program and far-flung its various components, there is a strong sense of "family" among the staff. From the executive director to program staff, there is a commitment to nurture one another. This sense of family greatly enhances communication and service coordination, and, most importantly, minimizes youths' ability to split staff into factions.

Also aiding communication and coordination is the fact that many staff have worked in several components. Effective programs encourage staff to gain experience in different components not only as a means of enhancing skills needed in holistic care, but also as a strategy for alleviating staff burn-out. The fact that many staff then are familiar with multiple components improves understanding among components.

Service integration also is achieved by good casework. Individual staff are accountable for coordinating services across components for individual youth. Caseworkers make sure that youth have access, not just to services that meet basic needs, such as food, but also to supportive services, such as counseling, that assist youth in making more enduring life changes.

Effective programs do not "label" a youth as "belonging" to one component or another (a propensity of categorical systems). Services are mixed, matched and adapted to meet each youngster's particular needs. Categorical systems, on the other hand, tend to exclude youth who do not meet the requirements of a particular service component.

Successful programs also demonstrate flexibility to blend dollars in ways that categorical programs do not, to ensure that youth who need a particular service are not excluded based on funding source criteria. For example, in Albuquerque, YDI is able to enroll youth in its Stay-in-School component who do not meet the income criteria of the component's principal funder—the Job Training Partnership Act—by adding county funds to the program as well.

Finally, effective programs utilize creative methods to engage youth in core services. For example, at UAY in Iowa City, staff use their training in the arts and music to draw youth into drug counseling.

In the sections that follow, issues and strategies relating to ten major service areas are discussed:

Substance Abuse
Mental Health
AIDS Prevention and Education
Medical and Dental Care
Housing
Emergency Shelter
Outreach
Gang Intervention
Education
Employment and Training

SUBSTANCE ABUSE
PREVENTION, EDUCATION AND TREATMENT

Issues

Along with housing alternatives and mental health services, substance abuse treatment services were cited most often by the programs we visited as being inappropriate, unavailable or inaccessible to runaway and homeless youth. Programs reported a serious dearth of **all** substance abuse treatment services tailored specifically to the needs of adolescents, but, in particular, public sector detoxification services, day treatment and inpatient programs were nearly non-existent.

Youth workers at all the programs told us repeatedly that the need for drug treatment services had reached crisis proportions in the last five years. Youth with whom we spoke discussed using drugs to dull the pain from cold and hunger and to medicate themselves for untreated physical ailments. Drugs also are used to dull the psychological pain of repeated rejections, abuse, fear, loneliness and disappointments that most street youth experience.

Drugs also are a significant source of income for street youth. In addition to prostitution, youth depend on drug dealing to provide the income necessary to meet survival needs. Finally, drugs play a central role in the social and friendship rituals that bond street youth together as a "family".

It is evident from talking to street youth that their dependence on drugs goes beyond the urgency to get high. Unfortunately, traditional drug treatment—the little that is available in the cities we visited—does not provide intervention that addresses the close connections between drug abuse and physical illness, depression and poverty. The need for specialized, comprehensive drug treatment that includes case management services, which could link street youth to other ancillary services, has been well documented (Hawkins, et al., 1987). Indeed, at many of the programs we visited, the distinction between substance abuse and mental health counseling is intentionally blurred because staff believe that drug use among youth is so integrally related to their psychological pain and stress.

In some cities, appropriate substance abuse treatment services simply do not exist at all. In others, the services that are available are provided by the private, for-profit sector and are inaccessible to youth without the ability to pay. Staff at several programs expressed concern over the dramatic growth in recent years of for-profit substance abuse (as well as mental health) treatment services in their communities. These services are inaccessible to poor, uninsured adolescents. Even adolescents who are Medicaid-insured are rejected by for-profit providers who will not accept Medicaid's relatively low reimbursement rates.

Youth workers also were concerned about the inappropriateness of some for-profit services that emphasize the most restrictive form of treatment—i.e., 30-day inpatient care—with no step-up or step-down services. Staff also expressed concern that, where treatment is available, there is often a requirement for family participation, which excludes many homeless youth.

In some instances, substance abuse services provided by the public sector are available only to youth referred by either the juvenile justice or child welfare systems. Thus, runaway and homeless youth, who may not be involved with either of these systems or, more likely, have fled, been ejected from or rejected by these systems, face a Hobson's choice if the only services available require a "system" referral.

Every city indicated that most public substance abuse treatment services provided in their communities were geared to adults, not adolescents. Alcohol detoxification programs, for example, are seen by both youth and practitioners as serving "derelicts"—that is, older alcoholics living on the street. This impression is understandable, given that the publicly funded system was designed initially to serve the adult alcoholic (Ooms and Herendeen, 1989). Even the Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) model available in many areas, with its emphasis on accepting the notion of being a lifetime addict and of taking one day at a time, was viewed as a difficult model for runaway and homeless youth to embrace. As a substance abuse counselor in one of the programs put it: "It's hard to teach our kids NA or AA. They have trouble seeing anything long-term, much less that they might be an 'addict for life' or have an 'incurable disease', so they relapse more than adults involved in NA or AA."

Existing substance abuse treatment services, whether public or private, were viewed as being particularly unsuited to the needs of cultural and ethnic minority youth. Much recent literature corroborates that services tend not to be culturally relevant nor to involve sufficient numbers of minority or appropriately trained staff (Rahdert and Grabowski, 1988).

Where appropriate services may be available, either through the for-profit, nonprofit or public sectors, youth workers report that long waiting lists are the norm. Public and nonprofit providers especially are overwhelmed.

A particularly critical gap is the absence of programs for youth with dual diagnoses of substance abuse and emotional disturbance. The importance of treating substance abuse and emotional disturbance simultaneously was confirmed in a 1990 Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) study of mental illness and drug addiction which revealed that over half of all persons with a substance abuse problem also had a diagnosable mental illness. The significant rate of mental disorders among alcoholics and drug abusers may help to explain the high failure rate of most treatment programs, the study suggested. The co-existence of mental illness and substance abuse raises special concerns for homeless and runaway youth programs, since a significant number of adolescents with depressive or anxiety disorders are likely to self-medicate with alcohol or drugs (Regier, 1990).

The fact that substance abuse treatment services are unavailable, inaccessible and inappropriate, combined with the increasing numbers of runaway and homeless youth who are drug-involved, has created internal tensions at the programs we visited. Should they attempt to develop greatly needed but highly specialized treatment programs? If services were more readily available in the community, programs would prefer **not** to develop their own detoxification, residential or inpatient programs. These services require high levels of staffing and specialized staff, which are expensive. Also, staff argue that these services **should** be provided by those with the formal mandate and expertise to provide them—i.e., public substance abuse agencies. On the other hand, programs despair of appropriate services ever being made available, especially since the federal government's shift in the last decade from funding treatment services to funding prevention and education.

Some of the programs we visited, such as San Diego Youth and Community Services (SDYCS), have decided that a decade of neglect is enough. "If we allow youth to come into the shelter high every night, we are enabling their addiction; if we turn them away, we are abandoning them," an SDYCS staff member told us. Rather than wait any longer for appropriate services to be initiated by public agencies, SDYCS established a comprehensive day treatment facility for adolescent substance abusers through a contract with the county.

Except SDYCS, none of the programs has opted to provide its own detoxification, residential or inpatient services, and most seemed reluctant to do so. They prefer to access treatment from experts in their respective communities; most of the programs have made considerable effort to develop partnerships with appropriate substance abuse providers where they exist. All of the programs we visited are engaged, however, in a variety of prevention and education activities and all provide substance abuse outpatient counseling services. The sophistication of these counseling components varies widely, however; many do not necessarily utilize certified or trained addictions counselors.

There is no question that the dearth of drug treatment causes tension for service practitioners. There is no agreement among staff or board members on the direction to take. Complicating the dilemma is the fact that research on effective services for adolescents is still in its infancy, resulting in a lack of guidance on what type of treatment should be developed (Hawkins, et al., 1987; Kumpfer, K., 1987); and, the fact that funders are more inclined to fund prevention and education than treatment services.

In order to understand the complexity of the drug habits of homeless and runaway youth, it is important to emphasize the variety of substances in common usage and easily available. In all cases, poly-substance use was a commonly identified problem, and every city cited alcohol as the most commonly abused substance. Recent research indicating that adolescents are poly-substance users, most typically mixing marijuana and alcohol, corroborates the information we collected (Bailey, 1989; Newcomb and Bentler, 1989).

The seven cities we visited each reported that different youth populations favored a different combination of drugs. For example, Albuquerque reported crack as a problem among African American youth, but not among Hispanic youth (at least not yet). Seattle indicated that pregnant adolescents seem to be more involved in cocaine and crack, probably because these substances are being supplied by their pimps. In Seattle's University District, where rockers and punks make up most of the street population, marijuana and LSD are common. In the downtown area, which is more racially mixed and where male prostitutes are more predominant, IV drug use is more in evidence. Even though effective programs recognize that they are treating the whole person, rather than a particular drug, the diversity of substance use among high-risk youth can further complicate efforts to develop effective prevention, education and treatment strategies.

In general, cities reported substances of choice as follows:

Albuquerque: Alcohol, marijuana, crack

Boston: Alcohol, cocaine

Chicago: Alcohol, marijuana, cocaine (some crack)

Des Moines: Alcohol, marijuana (some crack)

Iowa City: Alcohol, marijuana (some cocaine)

San Diego: Alcohol, crystal methamphetamine, crack

Seattle: Alcohol, crystal methamphetamine, marijuana (some crack)

Viable Strategies

Youth Development, Inc. (YDI) in Albuquerque takes an empowerment approach to substance abuse prevention and education. YDI draws on the strengths and talents of neighborhoods, families and youngsters as the basis for its prevention and education programs. For example, YDI's primary drug and alcohol prevention program, *Teatro Consejo*, uses theatre as its educational vehicle. Teatro teaches youth to develop and act in improvisational plays that

focus on the risks of substance use. The program targets two high-risk populations: children eligible for services under the Head Start Act and youth who are at risk of dropping out of school. YDI made a conscious decision to target very young children, as well as adolescents, because the average age for the onset of alcohol abuse in New Mexico is nine years old.

High school students at risk of dropping out of school and at risk of substance abuse are recruited by Teatro outreach workers to write and perform plays about relevant substance abuse issues. The plays, which are performed at middle school assemblies, are followed by classroom discussions led by YDI staff to reinforce refusal skills and no-use messages communicated by the plays. In addition to in-school performances, plays are performed in the community, at recreation and community centers, particularly in the summer months. For younger elementary school children, Teatro performs puppet shows.

Although Teatro will serve any area of the city upon request, it targets Albuquerque's South Valley and downtown areas, which are especially high-risk impact areas. In 1988-89, the program reached over 2,000 children and youth. Teatro employs six full-time staff and one part-time staff person and uses community volunteers.

Teatro was federally funded in 1987 as a three-year demonstration project by the Office for Substance Abuse Prevention (OSAP). Its budget is approximately $160,000, although YDI had attempted to secure $210,000 to include a family therapy component. At the time of our site visit, YDI had just learned that, although OSAP considers Teatro a model program, its funding had not been renewed because Teatro lacked an "acceptable" evaluation component, according to OSAP's Grant Review Committee. Teatro's experience in this instance raises issues for federal funders and direct service providers alike. Increasingly, the panels created by funders to review grant applications are insisting on methodologically sound evaluation components to ensure that scarce dollars are spent effectively. However, federal grant reviewers are often unfamiliar with the difficult task of running a direct service program and the constraints that prevent providers from implementing an evaluation component. Direct service providers usually lack experience with research and evaluation design models and do not have funds to hire outside consultants. If they

do not have a relationship with a university that could provide this expertise, they are especially hard pressed to design evaluations that will meet federal standards.

Project Poder is another example of YDI's empowerment approach to prevention and education. Poder is Spanish for "to be able". The program provides comprehensive services to three public housing projects in high impact areas for substance abuse. Services focus on community development and prevention, including neighborhood clean-up, gang intervention services and referrals to other YDI components. Project Poder is staffed by two outreach workers and is linked to the *Alamosa Community Center,* another YDI program. The Alamosa Community Center is located in one of the housing projects targeted by Project Poder, and provides a structured program for youth, including youth and family counseling, community pride projects, a drop-in recreation program and linkage to other YDI components. Project Poder and Alamosa Community Center are funded by the city's Housing Authority and its Department of Parks and Recreation.

In addition to Teatro and Poder, YDI considers its *Latchkey Recreation Program* a prevention initiative. Latchkey provides after-school, drug-free recreation activities, such as intramural sports, Las Senoritas Drill Team, Little Roadrunners and bilingual theatre, as well as a summer program at community centers, parks and schools. The program serves elementary and middle school students who live in underserved drug- and gang-ridden neighborhoods. Latchkey employs two staff and 40 volunteers and reaches over 6,000 youngsters. The program is funded by the city's Department of Parks and Recreation.

In addition to its prevention and education activities, YDI also provides some substance abuse treatment services. It runs a Children of Alcoholics Group one night a week for youth involved in its *Stay-in-School–Project Succeed* program. YDI also incorporates individual substance abuse counseling in the majority of its programs serving high-risk youth, including its Gang Intervention Project, its Community Corrections/Institutional Diversion Program and its residential programs. Recently, YDI was funded by the State Department of Health and Environment to operate the *South Broadway Substance Abuse Program,* which targets elementary and middle school youth in an older, gang-ridden neighborhood in Albuquerque that is

predominantly African American, but which has experienced a recent influx of families from Mexico (and Mexican youth gang members called the Juaritos). The South Broadway program employs two counselors who conduct group and individual substance abuse counseling, groups on self-esteem building and sexuality; and, gang intervention.

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Bridge in Boston operates a structured, state-licensed outpatient substance abuse counseling component at its drop-in center. (See also Mental Health Section in this Chapter.) Indeed, substance abuse is the focus of most counseling provided at Bridge, except for the crisis-oriented counseling provided to younger runaway youth. Substance abuse counselors, who are either certified addictions counselors or have significant experience in addictions counseling, provide intake and assessment, advocacy, short- and long-term substance abuse and psychological counseling. Each of the four substance abuse counselors meets with about 80 youth a month, about 25 to 40 of whom are engaged in long-term counseling. Bridge requires that its counseling staff have a minimum of five years experience working with youth and a background in substance abuse counseling. Masters-level training and certification in substance abuse counseling are preferred. Bridge recruits staff who have worked in non-traditional (non office-based) settings that require a great deal of flexibility. The counseling staff receives four weeks of initial training, as well as in-service training, which Bridge pays for or provides. Bridge also has an ongoing staff support group for counselors, which helps to prevent burn-out and to keep staff and administrators up-to-date on issues. At Bridge, substance abuse counseling and case management (or casework) functions are integrated. Most youth come to Bridge looking for basic survival assistance. Through the process of helping youth to meet these survival needs for food, shelter and clothing, counseling staff begin to develop a therapeutic alliance, gradually drawing youth into supporting services, such as substance abuse counseling. Bridge is developing a substance abuse outpatient counseling curriculum.

In late 1989, Bridge received a grant from the U.S. Department of Health and Human Services for family intervention. As a result, Bridge has increased its efforts to provide alcohol

and other drug counseling to parents of runaway and homeless youth, as well as referrals to community agencies.

The substance abuse component provides long-term counseling to about 500 youth a year. It is staffed by four counselors and is funded by the Massachusetts Department of Public Health, Division of Drug Rehabilitation and Alcoholism.

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Neon Street in Chicago utilizes interagency collaboration as its principal means of providing youth access to substance abuse prevention, education and treatment services. Neon Street is a member of a seven-agency collaborative, called *The Lakeview Substance Abuse Prevention Project,* which targets youth in the Lakeview district where Neon Street is located. Each agency brings particular resources and expertise to the collaborative, which are then available to all youth served by the project. Participating agencies provide outpatient assessment and counseling services, inpatient and residential treatment, outreach and specialized services for gay and lesbian youth. The project is federally funded by the Office for Substance Abuse Prevention through the Illinois Department of Alcohol and Substance Abuse; Neon Street's share of the funding is about $40,000.

Neon Street, through the Lakeview collaborative, has an on-site substance abuse counselor at its drop-in center, who provides individual and group counseling. The counselor, who is licensed as a certified addictions counselor, carries a caseload of about 26 youth for individual counseling and runs the following groups: two groups for youth abusing drugs; two groups for youth from substance abusing families; and, one prevention group.

Besides its participation in the Lakeview consortium, Neon Street has an interagency agreement with the Chicago Department of Health to accept referrals of Neon Street youth for assessment and treatment services at the Chicago Alcoholism Treatment Center, in return for which, Neon Street accepts youth referred from the Alcoholism Treatment Center for housing, emergency services, independent living and other services Neon Street offers.

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With recent funding from the federal Runaway and Homeless Youth Act, the **Iowa Homeless Youth Center (IHYC)** hired a full-time drug abuse counselor. "Almost all of our kids come from alcoholic homes, so it's not surprising that 95% of them have serious alcohol problems," staff told us. A major goal of IHYC's one-on-one counseling is to convince residents who continue abusing drugs to enter a nearby 30-day detoxification and treatment facility that accepts Medicaid (called Title 19 in Iowa). The treatment facility has agreed to accept not only those youngsters who have been approved for Title 19, but also those whose applications are still pending. Due to a special understanding with the local Title 19 office, applications for IHYC youth are processed within 48 hours.

For those youth who do not require residential drug treatment, IHYC provides holistic counseling that begins with an individual psychosocial assessment. Using her background in music therapy, the drug abuse counselor has each resident design a record album cover and choose 10 song titles that comprise an "autodiscography". For example, *No Place For Me* was the title of one youngster's album; discussing the meaning of her record's title and songs formed the basis for several subsequent therapy sessions.

Drug education, including the feelings that give rise to the need for drugs and alcohol, are frequent themes in all IHYC's counseling sessions. Counselors emphasize the need to say "good-bye" to friends who are drug users. Because residents stay at IHYC for as long as two years, there is an opportunity for a gradual process of weaning to take place, strengthened by the new bonds that inevitably develop among residents.

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Two years ago, **San Diego Youth and Community Services** requested funding from San Diego County to launch a drug treatment center that includes a day treatment program and a drop-in center. Although the County turned down SDYCS's initial request for funding, the treatment model described in the SDYCS proposal was adopted as the basis for a County Health

Department Request for Proposals (RFP). In response to the RFP, SDYCS resubmitted plans to establish its Adolescent Recovery Center[7] in an impoverished residential area of San Diego and won the contract.

With a $300,000 contract and two city-donated abandoned houses, SDYCS had adequate resources to hire 12 staff to operate a day treatment program serving 15 to 20 youth. Many of the 20 slots are filled with referrals from other SDYCS programs, especially The Storefront. The Adolescent Recovery Center's drop-in program is open to all neighborhood youth (not just SDYCS clients), who also may use day treatment slots. Youth may stay in the day treatment program for as long as six months.

The Recovery Center provides a comprehensive drug treatment program, which includes regularly scheduled Alcoholics Anonymous and Narcotics Anonymous meetings; an accredited on-site school; an independent living skills component; case management (providing links to all services outside the Center); mental health counseling; recreation, outreach, school-based prevention and a drop-in program for self-referred clients that is open weekdays and most evenings and weekends.

To transform the two abandoned houses into a drug treatment center, SDYCS used board connections to convince several local builders to renovate the facility—including the installation of a new kitchen—without charge. The landscaping and painting were also accomplished without cost by "hiring" persons who had been sentenced to perform community service, as well as using volunteers from local service clubs.

Initially, nearby residents and neighbors of the Recovery Center adamantly opposed the establishment of a drug treatment facility in their "backyard". SDYCS orchestrated a campaign to neutralize their resistance, which included: upgrading the appearance of the neighborhood by renovating and landscaping the buildings; persuading a City Councilman to locate his

[7]Although the Adolescent Recovery Center opened in August 1990, several months after our site visit, it is included in this report due to the importance of new drug treatment models to practitioners in the field.

neighborhood office in one of the Center's buildings; appointing a neighborhood advisory board; and, finally, conducting a walk-through of the neighborhood with the Councilman, who was well-known to neighborhood residents.

MENTAL HEALTH

Issues

Until 1980, the American Psychiatric Association's Diagnostic and Statistical Manual cited "Runaway Reaction" as a symptom of emotional disturbance. Such labeling, which failed to take into account the different circumstances—such as persistent poverty, abuse or neglect—that might motivate a youth to leave home, increasingly, is giving way to individual psychosocial assessments of each youth who seeks shelter.

The program staff we interviewed described numerous instances in which leaving home served an adaptive purpose. A teen living in an abusive, destructive environment, for instance, may demonstrate evidence of admirable coping skills by leaving home. It is in this context that Robertson warns "policy makers, researchers and service providers [to] guard against the 'medicalization' of homeless adolescents and the premature labeling of homelessness ... as a psychiatric problem" (Robertson, 1988).

Although youth workers caution against automatically assuming that all runaway and homeless youth are suffering from emotional disturbance, they, as well as researchers, confirm that mental health problems within this population seem to be growing more severe, complex and widespread than a decade ago. Recent studies report consistently high rates of all indicators of emotional disorders among homeless youth (Yates, et al., 1988; Shaffer and Caton, 1984). A 1988 Hollywood, California study reported rates of major depression, attempted suicide, anxiety, and post-traumatic stress that were at least three times higher than those among a non-homeless comparison group. In addition, a large percentage of the Hollywood cohort received a dual diagnosis of emotional disturbance and alcohol or drug abuse (Robertson, 1988).

A 1984 New York City study of youth in homeless shelters found similar rates of emotional disturbance: 33% of the girls had previously attempted suicide, and 37% of the boys had previously been charged with an offense, most often robbery or assault. The New York study concluded that "shelter users have a psychiatric profile largely indistinguishable from adolescents attending a psychiatric clinic" (Shaffer and Caton, 1984). In two separate studies of youth who were excluded from shelters at intake, it was reported that the most common reasons for exclusion were severe emotional problems (e.g., psychosis), suicidal threats, drug addiction and intoxication (Chelimsky, 1982; Rothman, 1985).

Although reliable national data on the mental health status of homeless youth is sparse, there is ample evidence to suggest that most homeless youth grow up in severely chaotic homes:

- Three-fourths of the youth in federally funded shelters reported having moderately or extremely severe problems relating to their families; 36% reported parental neglect, and 26% experienced physical or sexual abuse (U.S. General Accounting Office, 1989).

- Environmental risk factors, such as poverty, ethnicity, socioeconomic status and stress (which rarely occur in isolation from one another), make homeless youth more vulnerable to developing mental health problems (U.S. Office of Technology Assessment, 1986).

- The National Network of Runaway and Youth Services asserts that 61% of runaways who come to emergency shelters have been severely physically or sexually abused (USA Today, 1989).

Every program we visited reported that its caseload of youth with serious emotional disturbances has increased in the last decade. "We are the last resort. When the schools fail, when families fail, when the health and child welfare systems fail, we get them," was one program director's lament. As the child welfare system, for example, has become overwhelmed in recent years, the practice of "targeting resources" on younger children (usually under the age of 12), who have been seriously abused or neglected, has meant that older adolescents cannot gain access to help.

Each of the sites reported an alarming lack of available and appropriate resources in their communities for mental health treatment, as well as a lack of in-house treatment expertise. The

paucity of services for homeless and runaway adolescents is just one aspect of the general dearth of mental health treatment for all children, most especially for all poor children. National studies confirm that, among the three million children and adolescents who have severe emotional disturbances, two-thirds do not receive treatment (Knitzer, 1982).

Since the Children's Defense Fund published its landmark study documenting the "dismal" state of children's mental health services (Knitzer, 1982), policy makers and advocates have reached a consensus on an appropriate model system of care, with particular focus on inter-agency collaboration, a rich array of intensive non-residential services, parental involvement and attention to cultural and ethnic minority differences. This conceptual model first received national attention in 1984, when the National Institute of Mental Health's Child and Adolescent Service System Program (CASSP) promulgated a blueprint for state mental health planning. Currently, the CASSP concept has been adopted by virtually all of the states. Yet, "the discrepancy between the conceptual model of what a system of care should be, as embraced by state policy makers, and its actual implementation at a grassroots level is, in many cases, enormous" (Duchnowski and Friedman, 1990).

The program staff we interviewed attributed the lack of appropriate children's mental health services in their communities to these factors:

- Community Mental Health Centers (CMHCs) have few staff available to perform emergency evaluations or treatment. Most Centers provide assessments, but have no capacity to provide ongoing therapy, or to out-station staff at shelters or alternative high schools. CMHC staff are not trained to work with runaway and homeless youth, particularly those who are members of cultural, ethnic or sexual minorities. Where there are trained therapists, there are long waiting lists.

- Available treatment is mainly office-based psychotherapy by appointment—an unrealistic mode of service for runaway and homeless youth. In order to qualify for Medicaid reimbursement, some states are urging providers to become certified by the Joint Commission on the Accreditation of Health Organizations, which further encourages this medical model of care.

- Third-party reimbursement criteria continue to favor inpatient care, rather than community-based treatment. Even those youth who need hospitalization require follow-up outpatient care, which is unavailable.

- Alternatives to inpatient and residential treatment, such as day treatment and partial hospitalization, are practically non-existent due to funding and reimbursement barriers, resulting in inappropriate inpatient hospitalization.

- Runaway and homeless youth who do need inpatient care cannot get admitted to state facilities because they are not referred from traditional systems.

- Youth are discharged from state psychiatric inpatient units with no access to "step down" services and no aftercare plan.

- The proliferation of for-profit mental health hospital beds for children drains children's mental health personnel from the public system.

- Most for-profit facilities are inaccessible to uninsured or Medicaid insured youth. The few for-profit inpatient programs that do admit indigent children often have admissions criteria, such as parental participation, which exclude homeless youth.

- Clinicians often lack expertise in treating runaway and homeless youth; yet, they contend that runaway and homeless youth providers lack the training and credentials to provide good mental health services. Thus, there is tension between the two communities that further hinders service delivery.

- There are virtually no appropriate services for youth with dual diagnoses of substance abuse and emotional disturbance. There is also an extreme shortage of treatment resources for youth who have been physically and sexually abused.

- There is little prevention or early intervention with troubled families, which could help prevent homelessness.

Despite data demonstrating that millions of children need mental health services, funding for the federal Alcohol, Drug Abuse and Mental Health Block Grant has dropped 30% in real terms since 1981. Furthermore, only 10% of the Block Grant is set aside for children and youth with serious emotional disturbances. There is some evidence that community mental health centers, when strapped for funds, are cutting back on children's services, principally because children's services involve more personnel and, therefore, are more costly than adult treatment (Select Committee on Children, Youth and Families, 1989).

Each of the programs we visited emphasized the importance of having staff on site who could distinguish youth who require an immediate psychiatric evaluation from those who need only

the in-house crisis intervention that almost all youth who come into shelter require. Although staff at the programs were confident, for the most part, of their ability to make such differential diagnoses (as a result of their formal training or in-service training), they are aware that far more specialized mental health expertise is needed for youth requiring treatment.

Programs serving runaway and homeless youth all have staff who provide counseling, casework or case management services. For the most part, however, they are not trained or credentialed mental health professionals. In fact, they were hired to be residential counselors in shelter and transitional housing components, intake workers at drop-in centers, street outreach workers or youth workers performing any number of functions. They are usually B.A. level (or less), often have years of valuable experience working with youth and may be indigenous to the population being served. The type of counseling they provide is non-traditional, problem-solving, goal-directed and, usually, short-term; and, it is often very effective with runaway and homeless youth who have little interest, at least initially, in more traditional forms of psychotherapy.

As the mental health needs of runaway and homeless youth have become more severe, however, programs report an increasing need for access to greater clinical expertise than their in-house staff is able to provide. Most programs would prefer not to develop their own clinical treatment components but to access services from the mental health system. In every community we visited, however, this option is severely limited. As a result, programs are moving in several directions to try to fill the gap. Several programs have created a position of clinical director, staffed by a mental health professional, and others are considering this option. Other approaches include development of in-house clinical components, more extensive use of outside consultants or more in-service training for case workers.

Many programs are now providing in-house group, individual, milieu and family therapy, utilizing the public system mainly for emergency back-up. This solution is not only expensive, it has also caused philosophical problems for those staff who "don't want this place to become a mental health clinic." Many staff also contend: "We can be a catch-all for the Department of Social Services, but not for the Department of Mental Health."

Viable Strategies

Although **Bridge** in Boston provides both individual and group counseling, staff emphasize that Bridge is not a clinical treatment program. With younger runaway youth, Bridge provides short-term, crisis counseling. With older homeless adolescents, Bridge provides substance abuse counseling, which may be long-term. Bridge also has developed expertise in counseling youth with AIDS and young male prostitutes.

Bridge requires that its counseling staff have a minimum of five years experience working with youth and a background in substance abuse counseling. Masters-level training and certification in substance abuse counseling are preferred. Bridge recruits staff who have worked in non-traditional (non office-based) settings that require a great deal of flexibility. The counseling staff receives four weeks of initial training, as well as in-service training, which Bridge pays for or provides. Bridge also has an ongoing staff support group for counselors, which helps to prevent burn-out and to keep staff and administrators up-to-date on issues. Bridge has contracted with a licensed psychologist to provide weekly peer supervision, as well as ongoing staff training with a focus on family systems. Runaway counselors, who are on 24-hour call, primarily provide crisis intervention to youth new to the program. In contrast, substance abuse counselors each carry caseloads of about 80 youth a month and provide long-term therapy. Residents of Bridge transitional living programs are required to be in counseling at Bridge or an outside agency in contact with Bridge. Altogether, the counseling component treats about 1,600 youth a year.

At Bridge, counseling and case management (or casework) functions are integrated. Most youth come to Bridge looking for basic survival assistance. Through the process of helping youth to meet these survival needs for food, shelter and clothing, counseling staff begin to develop a therapeutic alliance, gradually drawing youth into supportive services, such as counseling. Because Bridge believes that integrating these functions is crucial to helping teens exit street life, some staff are critical of adult homeless shelters that provide teens with only food and shelter (but do not provide an array of supportive services), making it possible for youth to remain on the streets. Bridge cautions, however, that its approach places a more difficult burden on its counseling staff.

The majority of funding for Bridge's counseling component comes from the State Department of Public Health, Division of Drug Rehabilitation and Alcoholism and the U.S. Department of Health and Human Services. Funding covers the salaries of two runaway counselors and four substance abuse counselors.

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For the past seven years, **YouthCare** in Seattle has employed a number of consulting mental health professionals to assist its drop-in center, outreach, residential and casework staff. Consulting mental health staff provide: individual case consultation; assistance with development and refinement of milieu therapy in YouthCare's residential programs; and, staff training and development, particularly with the integration of new staff into existing programs. Both staff and administrators at YouthCare cite the importance of having access to this adjunct clinical expertise since YouthCare itself is not a clinical treatment program.

In an innovative partnership with the State Department of Mental Health and the University of Washington, YouthCare received a three-year grant in 1990 from the National Institute of Mental Health's Children's Services Research Demonstration Program to implement and evaluate an intensive case management model with homeless adolescents. The demonstration will provide intensive case management services, at very small, 1:10 staff:client ratios, to 80 youth over an 18-month period, with one-year follow-up.

The demonstration will involve two control groups: (a) youth involved in YouthCare's programs, who receive regular casework services, and (b) youth who receive minimal to no casework services. The demonstration will evaluate individual outcomes, including: residential stability; self-esteem; mental health; social functioning as measured by involvement in delinquent activities, prostitution, substance abuse and peer relations; quality of life; and, independent living skills. Also, the demonstration will consider moderating variables, such as how the relationship between the youth and case manager affects services actually received. The demonstration also will develop a case management training curriculum.

The demonstration has the potential to yield important information about levels of case management that may be effective with certain homeless youth and help other programs structure case management components that are responsive to the diverse needs of this population.

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Albuquerque's **Youth Development, Inc.** (YDI) has incorporated a family counseling component into its Stay-in-School, alternative education component. The program works primarily with Hispanic families and has developed a counseling curriculum for this population, which was developed with input from parents. Parents identified the following issues as those with which they most needed help: substance abuse, for both parents and youth; AIDS education and prevention; and teen pregnancy.

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The **Iowa Homeless Youth Center** (IHYC) in Des Moines provides mental health counseling using both in-house staff and doctoral students from nearby Drake University, who act as group therapy co-facilitators, an arrangement that is mutually beneficial to both the IHYC and the University. Although all IHYC residents are required to attend the weekly therapy group, there is little resistance, since youth know that only "house issues"—not personal issues—can be discussed. Personal issues are reserved for individual and drug therapy sessions, which are offered to all residents. Youth are allowed to ease gradually into individual therapy once they have developed a trusting relationship with staff and have had a positive experience in the group. The counseling staff have Masters degrees in counseling and experience in working with youth in non-traditional settings. By helping youth to gain insight and accept responsibility for their problems, the counseling staff empower youth to accept responsibility for solving problems.

When residents move out of IHYC's transitional living center into its apartment program, they are required to continue in individual therapy at a community clinic. Many go to Drake University's Counseling Center, which has a sliding fee scale, beginning at $2. Iowa Homeless Youth Center pays for half the cost of this therapy and the youth pays for the other half.

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At **United Action for Youth** (UAY) in Iowa City, mental health services are divided into two broad components: prevention and counseling. All art, drama, music, literary and recreation activities, as well as the drug prevention rap groups, are the responsibility of the prevention staff. Family, individual and couples therapy are conducted by the counseling staff. However, the boundaries are blurred between these two modalities, which is one of the program's strengths. Youth who are reluctant to engage in therapy can ease in "through the back door" by participating first in prevention activities.

Through a collaborative agreement with the local shelter, all runaway and homeless teens are automatically referred to UAY for therapy and recreation activities. Teens who return home can continue in therapy for at least six weeks at no charge. Because of the multiplicity of modalities available at UAY, the counseling staff can invite the parents of a runaway teen to come in for a 10-week parent training course and for intensive family therapy. Families are not charged for these services; however, if the family is referred by a public agency or is under court order, the agency or the court pays UAY's fee.

The counseling staff at UAY provides a range of non-traditional therapies, including counseling for child abuse victims (which involves helping the youth testify in court), recreational and leisure-time therapy for youth from multi-problem families, detention supervision and diversion, as well as traditional family and individual therapy. All of these interventions are underwritten by both general operating funds and an annual contract with the Johnson County Department of Human Services (DHS).

UAY also provides in-home therapy twice a week to families referred by DHS or the judicial system, usually when a child is at risk of placement. DHS will pay for up to 15 visits a month. If sexual or physical abuse is suspected, the youth will be referred to a UAY victim support counselor, who acts as the child's advocate during family therapy or if removal is contemplated. For extremely disorganized families, DHS contracts with UAY to provide both in-

home monitoring, which helps families change their style of interaction, and community assistance, which helps families identify additional local resources, such as employment training.

DHS payments are calculated by service units, with only a prescribed number of treatment units allowed for each intervention. Although UAY is eager to serve DHS clients, staff report that this payment system, which can cause treatment to be aborted before completion, is unsatisfactory. The payment system also makes it difficult to project annual income since the number of service units and referrals from DHS fluctuate monthly. In the last quarter of 1990, for instance, DHS curtailed all referrals to UAY to cut back on expenses after its budget had been frozen by the Governor. As a result, UAY experienced a significant drop in income, although its expenditures stayed the same.

The conviction that every individual is capable of growth underlies all of UAY's therapeutic interventions. Called Unconditional Positive Regard, this philosophy creates an egalitarian environment in which youth and staff share many responsibilities for running the program. UAY's telephone crisis hotline, for instance, is staffed by a group of specially trained teen volunteers.

Because it offers a wide range of intervention strategies under one roof, UAY provides "one-stop shopping" for troubled families. In addition, its rich array of prevention activities helps to remove the stigma often attached to mental health services.

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At **The Storefront** in San Diego, "treatment" begins as soon as a youth enters the shelter. Every aspect of life inside The Storefront—the furnishings, the way youth are greeted at the door, the way the telephone is answered, how staff interact with teens and with one another is carefully designed to bring about emotional healing and to empower youth to leave the street. The rules and expectations of this "milieu therapy" are meticulously outlined in the program's Policies and Procedures Manual which defines acceptable behavior for staff, volunteers and youth who use the shelter.

Maintaining the milieu requires a high degree of consistency, which is achieved through frequent meetings and case conferences. Each day before youth are admitted to The Storefront, staff and volunteers meet for a "staffing" to review the status of current residents, discuss anticipated problems and refine strategy.

For youth whose lives have mostly been chaotic, The Storefront's order and structure ensure a safe, predictable environment that youth can learn to depend on long before they can trust staff. The daily schedule, which staff adhere to faithfully, establishes this orderliness from the outset. When residents are admitted to the shelter promptly at 6:00 p.m., a security guard outside the shelter makes certain that no one is admitted after 6:10 and that youth (or former residents) over age 18 do not gain admission to the shelter or loiter outside. Once inside, residents sign the attendance form and the chore list. After a light snack, their schedule includes:

6:10-7:00 p.m.	Resident counselors lead a community meeting; new residents are introduced, basic rules are reviewed and available services described for new members, including medical care, independent living, school and case management services. Residents report on their status, any successes or failures. Problems within the shelter (such as chores not done, racist remarks, etc.) are discussed. Residents prepare the kitchen for the evening meal which is brought to the shelter by United Methodist Church volunteers.
7:00-8:00 p.m.	Residents and staff eat together. Kitchen chores are completed.
8:00-9:30 p.m.	Intake interviews are completed with new residents. Case management appointments are scheduled for other residents.
9:30-10:30 p.m.	Mandatory evening meeting, which includes presentations from Alcoholics Anonymous, Planned Parenthood, AIDS Prevention, etc., is followed by group games, pool, board games or homework.
10:30-11:00 p.m.	Personal time for laundry, showers follows group activity. Lights out and all in bed at 11:00.
6:30-8:00 a.m.	Residents awake, shower, complete chores, eat breakfast and leave the shelter by 8:00 with a bag lunch.
8:00-11:00 a.m.	Residents can meet with case managers or independent living staff by appointment.
8:00-12:00 or 8:00-6:00	School Recovery center.

This daily schedule is an important aspect of The Storefront's mental health treatment; it establishes the "trade-offs" inherent in giving up street life, and ensures ample time each day for group and individual counseling.

All residents accepted for long-term shelter placement (after an initial three-day trial period) are assigned a case manager. The client and case manager complete an in-depth (five-page) interview and, together, develop a case plan. To promote coordinated services, case plans, which include both practical and psychological goals, are made available to all staff and volunteers.

The Storefront's case managers, like those at Bridge, integrate case management with counseling. Helping a young person gain access to medical services or an I.D. card is often the important first step in forming a therapeutic alliance. The Storefront's two case managers, both licensed therapists, use traditional short-term crisis intervention techniques to help resolve "here and now" problems. They also use "reframing", another counseling technique, to help youth re-evaluate experiences in a new context; for instance, a youth who equates street life with "freedom" is helped to realize that dependence on prostitution to meet basic survival needs is not tantamount to independence.

Many Storefront youth, especially those who have been sexually abused or who need psychotropic medication, require long-term, in-depth therapy. The Storefront's two case managers continue to counsel such youth until they can find an appropriate therapist in the community. Hooking youth up with community resources, such as a county mental health clinic which can continue to provide services after the youth has left the shelter, is a key aspect of empowering teens to become independent.

An outside consultant, who is a clinical psychologist, meets weekly with Storefront staff and volunteers to review case plans and the progress of current residents (or former residents who may return to the shelter for follow-up counseling). This two-hour consultation helps staff develop treatment plans, improve collaboration and resolve the difficult conflicts that arise when a decision that is in the best interest of the milieu (the program as a whole) may not seem to be in the best interest of a particular youth. For instance, if staff allow too many youth to stay on at The

Storefront as long-term residents, the shelter would no longer have enough beds to meet its principal mandate. Yet, sending a youth out to an uncertain future can be a wrenching experience for staff. The consultant, who has the advantage of emotional distance, can assist staff in making such decisions with minimal rancor and guilt. In short, the consultant is as important to preserving the mental health of staff as he is to promoting the emotional growth of Storefront residents and to preserving the all-important milieu.

AIDS PREVENTION AND EDUCATION

Issues

Our site visits corroborated recent research reports (National Research Council, 1990) indicating that homeless youth engage in a pattern of behaviors, including unprotected sex, intercourse with multiple partners, early onset of sexual activity, same gender sex, sex in exchange for survival needs and substance abuse—all of which put them at high risk for contracting HIV infection.

Obviously, the dearth of drug treatment facilities, mental health treatment, access to health care, independent living facilities, foster care, alternative education and job training opportunities noted throughout this report reduce the choices available to street youth, thereby increasing the likelihood of their engaging in "survival sex" and other high-risk behaviors. Despite the systemic social, economic and psychological factors that sustain high-risk sexual and substance abuse practices, youth workers in all the cities we visited are continuing to develop effective techniques for teaching AIDS prevention.

Much of the AIDS prevention education information and training material available nationally are not particularly relevant to the populations of youth served by the programs we visited. As one AIDS prevention counselor told us, "There is plenty of safe sex information available in San Diego; these kids aren't listening." One reason the message may fall on deaf ears is that much of the material is designed for adults (often for gay adults) and requires an adult reading level, which some street youth lack. Even literature targeted at a younger audience may

be ineffective with homeless youth, who typically ignore written materials, especially those that emanate from the health and social services establishment.

Much of the standard AIDS education material is particularly irrelevant to street youth, who must contend daily with their own desperate survival needs. AIDS "scare tactics" do not succeed with many street youth, many of whom have little interest in or capacity to think about the future. As one 15-year-old told us, "If I'm cold and hungry now, what difference does it make what happens to me in five years?" A 1990 federal study of AIDS education contends that the Centers for Disease Control has accomplished relatively little in providing HIV education to out-of-school youth (U.S. General Accounting Office, 1990).

The programs we visited cited a particular need for culturally sensitive education materials targeted to minority youth, standardized protocols in certain areas and more relevant staff training curricula. For example, Bridge in Boston, which operates a dental clinic for street youth, cited the need for standardized protocols for treating oral manifestations of HIV infection, a project that the federal government could undertake in collaboration with the American Dental Association. Programs pointed to the lack of training material on how to counsel disturbed, multi-problem populations at risk of HIV infection: much of the available literature comes from those who have worked with adult gay men who are stable and emotionally healthy.

Programs cited a need for more effective staff training with respect to AIDS. Without adequate preparation and an opportunity to explore their own values and prejudices, some youth workers are frank to admit their reticence to discuss sexual issues. Programs also cited a need for more relevant material on how to counsel staff to cope with issues of death and dying.

In addition to the inadequacy of much of the existing training and education material, it is difficult for many street youth to accept the reality of AIDS. Because the HIV virus has an eight- to ten-year incubation period, few of those who become infected in adolescence will become symptomatic in adolescence. In 1989, the Centers for Disease Control reported only 343 cases of adolescent AIDS nationwide. Few of the teens we interviewed actually knew other youth who

had contracted the disease. Since their friends have not died of AIDS, street youth may continue to deny that AIDS is a threat to their mortality.

In spite of this considerable list of barriers to effective AIDS prevention education, a number of the programs we visited reported that awareness has increased among the youth they serve. In particular, more heterosexual males, as well as minority males, understand that AIDS is not just a "gay" or "white" issue. Staff did not believe, however, that awareness has improved among their female clients, who continue to think of AIDS as a disease of gay men. While programs report increased cognitive awareness, they do not report corresponding behavioral changes. Street youth continue to engage in high-risk behaviors.

Youth workers cite a need for AIDS education efforts to be far more youth-centered, using such techniques as peer outreach and use of youth theater and music groups. Youth workers agree that information and materials need to be frank concerning sexual issues and safe sex practices, but some staff feel constrained by community norms or the opinions of funders. On the other hand, federal funds from the Centers for Disease Control were viewed as among the least burdensome funding source in terms of both constraints and paperwork requirements.

Programs differed in their attitudes toward HIV testing. Some programs do not encourage testing because it is believed that, whether the outcome is positive or negative, the effect on youth is detrimental. An HIV negative result may encourage teens to continue engaging in high-risk behaviors; if results are HIV positive, there is a woeful lack of follow-up care. Those programs that do encourage testing try to ensure appropriate follow-up support. Although there is a great deal of ambivalence toward the issue of testing, all of the programs have policies in place to ensure youth have access to testing and to protect confidentiality of testing procedures and results.

Viable Strategies

With a three-year grant from the California Department of Health/Office of AIDS, **San Diego Youth and Community Services** (SDYCS), which administers *The Storefront,* hired an AIDS educator to develop an AIDS education manual. In one compact ring-binder, the manual provides

the data, lesson plans, materials and exercises required to: educate youth service workers about AIDS; teach youth workers effective AIDS education strategies to use with their clients; and, train youth as peer educators (see Appendix C). Because the project proposal was a collaborative effort between SDYCS, the San Diego YMCA, San Diego Youth Involvement Project and South Bay Community Services, staff from a total of 11 agencies have participated in the training and, in turn, are training 150 additional staff and volunteers, who will work with a minimum of 2,000 youth in their respective agencies.

The manual maps out a series of 14 "Training of Trainers" workshops; each is four hours long and utilizes adult experiential, participatory learning principles. After an ice-breaker (such as a Condom Relay Race), a self-evaluation exercise (what do you know and how can you teach it?) follows. In subsequent sessions, participants review the medical and legal facts relevant to AIDS; they also learn (and practice) effective teaching techniques, such as how to conduct a workshop on gay and lesbian issues, or how to discuss masturbation.

After completing the Training of Trainers sequence (Phase I), participants are then prepared to train youth workers at their own agencies (Phase II) who, in turn, will provide AIDS education to San Diego youth. Finally, youth are trained as peer educators (Phase III).

The SDYCS AIDS Education Program is based on five important prevention strategies that, according to the field, are essential components of any successful intervention targeting teenagers. (National Research Council, 1990; Woodruff, Doherty and Athey, 1989; Boyer, 1988). They are:

1. AIDS educators must possess two distinct skills: first, precise cognitive information about the virus and its transmission, including safe sexual practices, correct answers to common misconceptions, HIV testing procedures, the meaning of test results and hygienic procedures for providing services to infected youth. In addition to technical competence, AIDS educators must be able to use street vernacular to participate in candid discussions—which often elicit deeply personal questions about their own sexuality.

2. Street youth are more likely to accept AIDS prevention information that is provided by adults with whom they have a relationship of trust and familiarity.

3. AIDS educators must actively involve youth in the training process. Rather than a lecture format, an ongoing small group provides opportunities for youth to role-play sexually pressured situations, to explore difficult personal choices and to develop their own youth-oriented AIDS prevention materials. As a result of one such small group at SDYCS, for example, participating youth wrote and illustrated an AIDS workbook that provides basic information and corrects prevalent myths.

4. Street youth cannot utilize AIDS education unless they also learn how to negotiate assertively with sexual partners, make difficult choices under duress and withstand ridicule. Acquiring these skills requires practice, peer support and self-confidence. At The Storefront, there are frequent references to self-protective behavior in the nightly group meetings, in individual therapy and in case management meetings where youth are taught, through role-playing, that being a "nice person" does not mean being passive and submissive.

5. Street youth cannot utilize AIDS education unless it is provided within a holistic social context that provides access to necessary sustaining resources, including food, shelter, clothing, medical care, mental health treatment, substance abuse treatment, education and vocational training. These resources, which empower youth to choose safe sex, are "as essential to AIDS prevention as condoms," one youth worker told us.

Because the threat of AIDS is so pervasive (and the solution so elusive), AIDS prevention is a constant presence at all the sites we visited. At most sites, condoms are readily available, and posters advertising safe sexual practices decorate the walls. At United Action for Youth, a youth-written safe sex rap song provides background music to the day's activities.

Self-empowerment strategies enhance the explicit AIDS education program at The Storefront, which also includes regularly scheduled on-site HIV testing performed twice a week. Testing is voluntary, and the results are kept strictly confidential. However, many youth choose to discuss test results with their case manager. Results are not entered into client charts or discussed with other staff unless the youth signs a release. Youth who test positive are given follow-up support counseling.

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Similar to the approach taken by San Diego Youth and Community Services, **Youth Development, Inc.** (YDI) in Albuquerque also has developed an AIDS education manual in ring-binder form for use in its "Training the Trainers" project (see Appendix C). YDI trains staff in five of its own components, as well as staff in 10 outside agencies. YDI, which predominantly targets Hispanic youth, trained over 600 youth and adult staff in 1989.

New Mexico's Health and Environment Department funds YDI's AIDS project with a budget of about $33,000 a year, which covers two full-time staff persons and materials. In addition to the training manual, YDI publishes an AIDS education newsletter every two months that is targeted to both staff and youth. YDI also serves on the Governor's Task Force on AIDS, which provides the agency with current information on AIDS-related issues and ensures that the issues affecting youth and the Hispanic community are heard at senior policy levels.

In addition to its "Training the Trainers" project, YDI operates *Project De SIDA,* which provides HIV education and prevention for Hispanic IV drug users and their families. It is the only program of its kind in Albuquerque. The project includes: street outreach, using skilled outreach workers from the targeted neighborhoods; counseling; theater developed by former IV drug users, who also perform in the plays; cartoon strips and other educational media; and, transportation to and from testing sites. To ensure effective outreach and build trust with clients, Project De SIDA works closely with a fundamentalist church group, Barrios for Jesus, that has had success reaching IV drug users.

Project De SIDA is funded by Centers for Disease Control monies channeled through the New Mexico Health and Environment Department. The budget is approximately $39,000, which covers two full-time staff persons, materials, transportation and a small subcontract to Barrios for Jesus for outreach coordination.

All of YDI's HIV prevention and education activities incorporate frank material on safe sexual practices and IV drug use and include the dispensing of condoms.

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At **Neon Street** in Chicago, AIDS education begins at intake. All youth who come to the drop-in center are asked what they know about AIDS to assess knowledge levels. As a part of their service plans, youth are required to attend Neon Street's AIDS education groups; in addition, youth at highest risk see the AIDS coordinator for individual sessions.

Neon Street's AIDS outreach predominantly targets minority male hustlers. The client population served is about 80% African American, 15% white and 5% Hispanic. All of the staff are African American and include two part-time (20 hours a week) outreach workers, five peer educators and the coordinator. Neon Street trains peers as educators and is beginning to use persons with AIDS as counselors.

In addition to outreach and education targeted to youth, the AIDS component provides in-service training for Neon Street staff and volunteers, both to keep them informed and to help them resolve their own conflicts concerning AIDS and cultural differences.

The AIDS component is funded by the Centers for Disease Control through the City Department of Health at a cost of about $37,000.

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YouthCare in Seattle provides both direct AIDS education to high-risk youth and training for individuals who work with youth. Like YDI and San Diego Youth and Community Services, YouthCare has developed a training manual in ring-binder form, that is targeted to youth at risk, called "Teen AIDS Prevention Education" or TAPE (see Appendix C). TAPE was developed by a Fellow in Adolescent Medicine at the University of Washington and modified by YouthCare to include more drug- and alcohol-related information.

YouthCare's training of trainers program provides eight hours of training, followed by monthly newsletters, periodic updates on reading materials and assistance with developing AIDS policy. Those who are trained receive the training manual and a YouthCare kit, which includes condoms, bleach, graphics on the "2 x 2" clean needle technique, pamphlets and an innovative

visual aid, called a "Measuring Tape", that vividly illustrates the current number of HIV-infected individuals nationally, the number in the Seattle area, how many are teens, and, as the tape is extended, how those numbers will grow dramatically over the next five to ten years.

The agenda for the training is divided into nine sections as follows:

Unit One: **NAMING BARRIERS TO INVOLVEMENT**

This unit helps participants address their personal fears about becoming involved with the issue of HIV/AIDS by listing the barriers that may prevent them from working effectively with high-risk adolescents.

Unit Two: **BASIC FACTS ABOUT HIV/AIDS AND THE POLITICS OF AIDS**

This unit provides the facts youth service workers will need to know about HIV/AIDS to conduct an AIDS prevention program with adolescents. The unit helps participants understand the social context which has influenced the delivery of AIDS education and prevention efforts and social policy.

Unit Three: **BUILDING CULTURAL AWARENESS**

This unit helps participants address their conflicts. The unit provides participants with the opportunity to examine their values, attitudes, stereotypes and past experiences that inevitably affect their ability to work with certain kinds of adolescents and health problems.

Unit Four: **SPEAKING THE SAME LANGUAGE**

This unit assists participants to become comfortable with presenting sexual issues and using sexually explicit language.

Unit Five: **SPECIAL NEEDS OF YOUTH**

This unit looks at the needs, conflicts, and sense of hopelessness, as well as the potential that characterize the high-risk adolescent. It addresses the current data on adolescent HIV/AIDS infection, developmental factors, typical high-risk behaviors, peer and community norms.

Unit Six: **RESPONDING TO RISKY ATTITUDES**

This unit examines the four typical categories of adolescent attitudes about AIDS. It prepares participants to recognize these attitudes and to address them clearly and directly.

Unit Seven: **RISK REDUCTION COUNSELING**

This is a skills building unit that provides participants with the techniques and "how-to" of HIV/AIDS prevention work with adolescents. The focus of this unit is on safer health and sexual behaviors and the need to avoid drug use in general and intravenous drug use in particular. Participants are taught how to advise adolescent clients about needed behavioral changes that can reduce their risk of HIV infection.

Unit Eight: **YOUTH AIDS CURRICULUM**

This unit models a Youth AIDS Curriculum that is designed to provide knowledge and shape attitudes so that youth may be empowered to reduce their risk of acquiring HIV.

Unit Nine: **WHERE DO WE GO FROM HERE?**

This unit, which completes the training process, outlines what is needed to operationalize HIV/AIDS prevention. This is a unit for sharing ideas and developing networking skills and resources.

(YouthCare, 1989)

In 1989, YouthCare conducted 36 trainings for over 450 service providers, including teachers, school nurses, youth ministers, physicians and staff at youth services agencies, at group homes and at detention facilities. Based on a follow-up survey to the training that YouthCare conducted, those trained, in turn, reached over 1,600 youth.

YouthCare also trains teenagers to be peer AIDS educators. It participates in the Seattle Youth Coalition for Peer AIDS Education, which involves youth in a two-day training retreat. Youth have written and performed in a play about AIDS and developed written materials and posters. YouthCare is developing a model for working with couples and hopes to use trained teen couples as peer counselors.

In addition to its Training the Trainers Project, YouthCare provides direct prevention education to about 150 youth a month, including those on the street and at its own program components, youth in detention, in substance abuse treatment programs and in other service agencies. A person with AIDS is often invited to these education sessions to talk with teens. In 1989, YouthCare reached over 2,000 youth through 350 AIDS classes.

YouthCare has a particularly innovative agreement with the Department of Youth Services juvenile detention facility. YouthCare's health educators are on 24-hour call to counsel teens brought into detention on solicitation charges; YouthCare workers visit the detention center daily, to link youth to YouthCare's services and to provide basic AIDS education. YouthCare provides youth, upon release, with condoms, informational material and a map to its services.

YouthCare's education approach, in addition to the frank discussion of safe sex and needle use that is the hallmark of all effective youth AIDS education projects, emphasizes the importance of a healthy lifestyle. The emphasis on healthy lifestyles includes such basic strategies as eating well and having a safe place to live. Teens also are taught to adopt practices unique to street youth, such as keeping a "black book" of known "clients", rather than cruising the street. This emphasis on a healthier lifestyle supports one of YouthCare's overall goals for street youth, which is self-care.

YouthCare's AIDS education and street outreach components are integrally related. All outreach workers are trained in AIDS education, and it is a major part of their work on the street. The AIDS/outreach staff have backgrounds in public health, case management and youth work.

YouthCare's AIDS component is funded by federal pediatric AIDS dollars (from the Health Resources and Services Administration, U.S. Department of Health and Human Services) channeled through the County Health Department; Centers for Disease Control monies channeled through the State Health Department; the State Division of Alcohol and Substance Abuse; federal Office for Substance Abuse Prevention (OSAP) monies; and, a Robert Wood Johnson Foundation grant. These funds cover two health educators, three full-time equivalent outreach workers and one AIDS/outreach manager.

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United Action for Youth (UAY) recently received funds from the Aetna Foundation to launch an AIDS education project. UAY invites teen couples to a weekly pizza party; participants are helped to talk frankly with each other about sex and to role-play "sexually sensitive" situations.

MEDICAL AND DENTAL CARE

Issues

The complexity of providing medical care to homeless teens may best be illustrated by the following typical case history:

> Stacey, age 16, was badly bruised and weeping when she came to a runaway shelter in the Midwest for the first time. She needed help, she said, because her boyfriend was promising to "let her have it" if she moved out. Five months pregnant, Stacey was convinced that if she stayed with him, she would continue to use drugs and something terrible would happen to her baby. Stacey had been out of school and living on her own for almost two years since she left home to escape an alcoholic step-father who physically abused her. Returning home did not seem like a viable option to Stacey or to the staff at the shelter.

Stacey's story illustrates how complex it is to secure help for homeless youth. Prenatal care alone will not protect her health, the health of her baby or their future. Equally urgent are her unmet needs for mental health treatment, drug treatment, nutritional counseling, housing, an educational assessment, school placement and employment skills.

The difficulty of providing adequate health care for Stacey is compounded because she is homeless and pregnant too soon. In fact, even for those who require nothing more than routine preventive care, the health care system for adolescents generally is inadequate, fragmented and inappropriate. Adolescents are the least likely of any age group to see a doctor (Children's Defense Fund, 1990).

Current research, as well as the observations of the youth workers we interviewed, attribute the lack of health care for adolescents to four principal barriers:

- Nearly one-fifth of all children and youth under 18 have no health insurance, public or private (Children's Defense Fund Clearinghouse Report, 1990).

- Teenagers and their families cannot afford to pay for health care. Even the poorest adolescents may be denied Medicaid eligibility in many states. Teens living on their own are frequently excluded from Medicaid if they cannot obtain parental permission or the required documentation, such as a birth certificate.

- Appropriate health care services for adolescents are in short supply. Particularly in many rural and inner city areas, there is a severe shortage of physicians willing to treat low-income patients, and there is a scarcity of adolescent age-appropriate services. Where such services are available, long waits for appointments, inconvenient hours and an impersonal attitude toward patients often prevail, which deter teens from accessing services.

- Fragmented, categorically defined medical services fail to address the social, psychological and environmental problems or the risk-taking behaviors that seriously endanger the health of adolescents.

Two publicly funded programs, Medicaid and its child health component, the Early Periodic Screening, Diagnostic and Treatment (EPSDT) Services program, have primary responsibility and potential for improving the health care of high-risk adolescents (CDF, 1990). Although Federal law requires the EPSDT program to provide regular medical screenings, diagnoses and treatment, including vision, hearing, mental health and dental services, for all Medicaid-eligible children and youth under the age of 21, many states have failed to implement the mandatory EPSDT guidelines. In 1988, only 13 of every 100 eligible six- to 20-year-olds received a screen (Children's Defense Fund, July 1990). In addition, the content of the screenings often omit tests related to mental health, sexual activity and substance abuse.[8]

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[8]In the Omnibus Budget Reconciliation Act of 1989, Congress enacted sweeping changes in EPSDT intended to improve access to care, encourage provider participation, enhance the content and frequency of health screenings and expand diagnostic and treatment services for poor children and youth. These federal guidelines are not mandatory, however. Each state designs and administers its own Medicaid services. To improve health care services for homeless and runaway youths in a particular community, state Medicaid agencies must first exercise the treatment options included in the 1989 federal legislation.

EPSDT screening and treatment services, like Medicaid, are resources that are untapped and under-utilized by most homeless and runaway youth programs, mainly because very few states and communities have fully implemented federal EPSDT and Medicaid options. Also, it is not easy for local providers to find out how to access those services that are available.

The lifestyles and attitudes of homeless and runaway youth add other barriers to those already inherent in the health care delivery system. Many street youth are unfamiliar with and wary of medical procedures. Youth workers report that many teens are fearful of having blood taken or of getting an injection. For adolescents with a history of sexual abuse or exploitation, having to undress for a physical examination can be traumatic. Further resistance to medical treatment often occurs because street youth suspect that medical staff will report the results of an examination, their whereabouts or information about their activities to their parents or to the police. Finally, any treatment protocol that requires more than one visit is jeopardized by the transient lifestyle of street youth.

These barriers, coupled with an unrealistic sense of their own invulnerability, allow homeless youth to ignore even painful or disabling symptoms and to postpone pre-natal care. Typically, teens convince themselves that health problems will eventually disappear. This misplaced optimism is particularly detrimental to the treatment of venereal disease, which is characterized by periodic temporary remission.

At the sites we visited where physicians work in specifically designed *alternative adolescent health components,* runaway and homeless youth are more likely to consent to medical care. In fact, at sites where there are alternative health clinics, medical services can be an "entree" to the comprehensive array of services that youth require (see also Boyer, 1988).

There is little doubt that significant numbers of homeless teens suffer from severely impaired health. A Los Angeles study of street youth, who were first-time patients at a free clinic, revealed a high incidence of syphilis, pelvic inflammatory disease, trauma, rape, hepatitis, asthma and scabies (Boyer, 1988). Conditions, such as cardiac arrhythmia, pneumonia, renal failure and

anemia, occurred much more frequently among runaway and homeless clients than among those who were living at home (Yates, 1988).

In a 1989 study of the health care needs of homeless and runaway youth, the Council on Scientific Affairs of the Journal of the American Medical Association (JAMA) identified six major health problems of homeless youth and warned against "glossing over" the very different treatment needs of homeless youth and homeless adults. JAMA found the following major areas of concern:

1. Nutrition. Most street youth reported eating one meal a day, at most. An Oregon nutritionist, who analyzed a typical shelter meal, determined that it provided only one-third of the daily calories needed for growth and was extremely deficient in iron, calcium, protein and vitamins. The JAMA study cited poor nutrition as having "frightening implications for the health and well-being of children born to homeless adolescent females."

2. Substance Abuse. There are no national data on the rates of alcohol and drug use among homeless youth, but regional studies and anecdotal information confirm rates far in excess of the rates for all youth. In a Hollywood, California survey, 61% of homeless youth admitted to substance abuse; one-third of the sample were chronic abusers and one-fourth had diagnoses of both alcohol and drug abuse. Yet, most substance abuse programs do not admit adolescents and, particularly, not uninsured adolescents, leading one researcher to call this a "largely untreated group" (Robertson, 1989).

3. Mental Health. Homeless adolescents are less likely than homeless adults to have ever received care in the mental health system, despite very high rates of depression, self-destructive behavior (including suicide) and anti-social behavior. Emotional problems underlie many of the risk-taking behaviors that further endanger the health of homeless teens.

4. Physical Health. Exposure to the elements, the absence of a clean domicile and opportunities for bathing contribute to many physical ailments, particularly the gastrointestinal, respiratory and genitourinary problems common among street youth. The unsanitary condition of street life promotes the spread of Hepatitis A and B, head lice, pubic lice, scabies, and impetigo.

5. Sexual Health. Incidents of all sexually transmitted diseases, including AIDS, have increased sharply in the last decade. The Centers for Disease Control attributes the 60% increase in the rate of syphilis since 1985 to the epidemic in cocaine use among the urban poor, which has exacerbated the practice of exchanging sex for drugs, a practice common among homeless youth.

6. Teen Pregnancy. Rates among homeless youth are even higher than the rates for domiciled teens. In the Hollywood survey, 44% of the females reported one or more pregnancies, although only 13.9% had ever given birth. (Robertson, 1989) In the Health Care for the Homeless Program's first year, nearly one-fourth of females, age 16 to 19, were pregnant at their first medical examination or became pregnant during the next year.

7. Victimization. Over 900,000 youths, two-thirds of whom are female, are involved in prostitution; their average age is 15 years. Nearly four-fifths of adolescent female prostitutes have been identified as runaways, and a sizable number of young males are runaways as well. Without an alternative means of support, homeless teens have few legitimate alternatives to prostitution, pornography or the sale of illegal drugs, all of which subject them to serious health risks, including physical and psychological trauma, AIDS and other sexually transmitted diseases (Council on Scientific Affairs, 1988).

Program staff with whom we visited would add dental health to the JAMA list. In some respects, dental services are even more inaccessible than medical care. Many insurance plans do not include dental coverage, and most states do not have an adequate system of public dental clinics. Staff point out that many street youth have had no dental care for years.

The prevalence of death, sickness and injury among homeless and runaway youth is unacceptably high mostly as a result of health damaging behaviors, rather than disease. Traditional, specialized medical services are inadequate to meet the challenge of these "new morbidity" health problems, i.e., conditions that result from social, rather than biological, factors. Just as effective AIDS prevention must be comprehensive and include housing, adequate nutrition, medical care, education and mental health treatment, recent evidence supports a holistic model of medical care capable of integrating all the related health needs of high-risk adolescents (Ooms and Herendeen, 1989).

Although few in number, comprehensive adolescent health programs have had notable success in overcoming the fears and logistical barriers that typically exclude high-risk teens from medical care. The youth workers we interviewed identified these important features of holistic services:

- Health professionals from all the relevant disciplines located at a single site or, if necessary, collaborative treatment relationships with other providers at several sites; staff caution that the more "stops" youth have to make to obtain health services, the less likely they are to receive care;

- A commitment to multi-disciplinary collaboration;

- Health screening and treatment protocols that include all relevant social, psychological and environmental factors which have an impact on teen health;

- Staff who have the ability (and the time) to talk with teens about their lifestyles in a non-judgmental manner and who accord youth the same respect as they would adults;

- Sensitivity to the special fears of sexually-exploited youth;

- Treatment that includes health education and family planning; and,

- Evening clinic hours and scheduling flexibility that includes some "drop-in" clinic hours.

Many physicians attest to a willingness to treat homeless and runaway youth, but assume that before providing medical care to minors, they must obtain parental consent. Uncertainty in this area is understandable since state laws differ, especially with respect to homeless youth who may be "emancipated minors", that is, exempt from parental consent requirements in some jurisdictions. Addressing this issue, the Council on Scientific Affairs of the Journal of American Medicine has requested that state medical societies: determine the extent of treatment allowed without parental consent under state regulations; inform doctors of existing laws affecting minors, including those who may be declared emancipated; and, form alliances with statewide youth advocacy groups to develop protocols for the treatment of troubled youth (Council on Scientific Affairs, 1989).

Physicians with whom we spoke, who have formed partnerships with runaway and homeless youth programs and are providing services either at programs on-site, through hospital emergency rooms or at free clinics, tend to downplay the parental consent issue. As one physician, who has been serving runaway and homeless youth for 20 years, put it: "This issue is often just a good

excuse for doing nothing; if physicians want to provide medical care to runaway and homeless youth, they can."

Viable Strategies

YouthCare in Seattle utilizes one of the oldest free clinic "systems" for runaway and homeless youth in the country. In the late 1960s, a few Seattle physicians, under the leadership of Robert Deisher, M.D., perceived that street youth were not utilizing the city's public health clinics; the only services adolescents were using were hospital emergency rooms. Deisher and a few colleagues started a free clinic specifically for adolescents by convincing an existing public health clinic to let them use the clinic's facilities one night a week. In the second year of operation, Deisher added medical students from the University of Washington and, eventually, Fellows in Adolescent Medicine to help staff the clinic. They advertised the availability of the clinic through public service announcements, flyers on the street and through youth services agencies. In the first year of operation, the clinic served about three or four youth a night.

Today Deisher, under the auspices of the University of Washington, has formal arrangements in place with YouthCare to provide an on-site clinic at Orion Center (YouthCare's drop-in center) and evening care, using public health clinics in Seattle's Pike Market District and in the Pioneer Square area. YouthCare staff transport youth by van to the Pike Market and Pioneer Square clinics; YouthCare's outreach workers also help youth to access the clinics. The three clinics now serve about 30 youth a week.

As a result of unique interagency collaboration and volunteer health care staff, Deisher's clinics operate on a budget of less than $2,000 a year. Obviously, the ability to utilize existing clinic facilities and equipment contributes to keeping costs low. In addition, all physicians and staff are volunteers, except for one nurse practitioner funded by the Health Care for the Homeless Project. The Seattle Department of Public Health provides free lab work; x-rays are provided at no cost (if a youth is uninsured) by the King County Hospital; most drugs, except for antibiotics, are donated by pharmaceutical companies, as are birth control devices.

Dr. Deisher, who now serves on YouthCare's Board of Directors, believes that a major factor in being able to operate clinic services for homeless youth on a very small budget is having access to a medical school in the community. Dr. Deisher is Professor Emeritus in the Department of Pediatrics at the University of Washington Medical School. To heighten medical students' awareness of the health care needs of this population, Deisher teaches an elective course on street youth.

Deisher believes that several basic factors are important in developing health clinics that youth will use:

- The facility itself must be decent. Youth will see the physical plant as a reflection of how staff view them and of the quality of care provided; youth will not utilize a shabby facility or one where they have to wait for hours to be seen.
- Youth must be treated with respect--for example, asked whether they prefer to see a male or female physician, or whether they mind being seen by a medical student.
- Services must be available at no cost to youth who are uninsured.

Dental care and psychiatric care are two services that the Seattle clinics have been unable to organize or access. Deisher explains that it is difficult to recruit volunteer psychiatrists and, while they have been able to get a few volunteer dentists, they have not had success structuring a dental component.

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Bridge in Boston operates the oldest mobile medical van in the country serving street youth and has one of the only on-site free dental clinics serving this population. Bridge's Clinical

Director provided the following description of its medical van and dental clinic in recent testimony before the U.S. Senate Subcommittee on Children, Family, Drugs and Alcohol:

> Since 1970, the Bridge Free Medical Van has brought important medical services to youth who might otherwise never find the help they need. Each week night, the van makes regularly scheduled stops in areas of Boston and Cambridge where street youth gather. A pool of 17 physicians and 41 nurses volunteer an average of one night per month. The use of volunteers constitutes a powerful message to these alienated youth that professionals do care about them and are willing to extend themselves to offer assistance. For many youth, trapped in a street life-style of instability and chaos, the regular appearance of the medical van offers the only positive structure in their lives. It is a front-line service reaching out to the neediest youth. In training medical volunteers, Bridge stresses to them that the manner in which their services are offered may be more important than the service itself. By providing medical care in an environment where youth feel comfortable, Bridge promotes trust, and clients are more likely to return for the other services they may need. Additionally, the van is used one day a week to provide outreach to young single parents living in welfare motels.
>
> The van, a converted mobile home, consists of a waiting area, two examination rooms, a small laboratory facility, and a small pharmacy. (Youth are aware that the van does not carry any medication with a potential for abuse.) The most common medical concerns treated on the van are upper respiratory infections, minor traumas including sprains, cuts, human bites, etc., sexually transmitted diseases and dermatological problems. Additionally, the waiting area is stocked with an array of alcohol and other drug educational materials as well as HIV educational brochures and resources. In addition to the medical staff, the medical coordinator and a street worker are available to respond to the psychosocial concerns of the youth.
>
> Approximately 800 youth make 3,000 medical visits annually to the van. Two thousand youth drop by for a sandwich, a cup of cocoa or someone to talk to. In combination with the Streetwork program, the van offers a powerful outreach presence to street youth.
>
> (U.S. Senate Select Committee on Children, Family, Drugs and Alcohol, 1990)

The Bridge Free Medical Van was the first of its kind in the country. Bridge estimates that it would cost approximately $60,000 today to purchase and equip a similar van. Operating costs, principally salaries for a coordinator and a part-time street worker and medical supplies,

amount to $70,000 yearly. In addition, the in-kind value of volunteer health care staff services amounts to another $30,000 yearly.

As a back-up to the Medical Van, Bridge offers an in-house Nurse Clinic which provides physicals at its drop-in center. This has been particularly helpful in coordinating medical services for Bridge clients who are HIV positive.

In a somewhat ironic footnote to our discussions about the van, staff noted that it was easier to establish credibility for the van with street youth than it was with the community and the police, who were reluctant to grant special permission and assistance with parking. Now, after a nearly 20-year track record, Bridge's relations with the community and the police are excellent, but the program cautions new providers to be aware of this potential hurdle. Indeed, YouthCare in Seattle, which recently began operating an outreach van partially modelled on that of Bridge, reported difficulties with the police over parking.

At the same Senate hearing, the Clinical Director of Bridge also described the program's dental services:

> The Dental Clinic is a three-chair fully-equipped facility. It is open four evenings per week in the Bridge main facility and offers a wide range of restorative services, with particular emphasis on preventative oral hygiene technique instruction. Over 50 volunteer dentists, hygienists and assistants provide services and educate clients about the procedures they will undergo. The education, combined with an informal low-key atmosphere, helps to allay patients' fears of dentistry. Approximately 475 youth make over 1,300 visits annually to the clinic.
>
> (U.S. Senate Select Subcommittee on Children, Family, Drugs and Alcohol, 1990.)

United Way funds the medical and dental components of Bridge. In addition, a $130,000 restricted endowment, made possible through the generosity of an individual donor, provides funding for a new van when needed (approximately every seven years).

* * * * * * *

Neon Street Center in Chicago has a unique interagency agreement with the Emergency Services Department of Illinois Masonic Hospital, a private, nonprofit hospital located a few blocks from Neon Street's drop-in center. The hospital provides free emergency assessments and treatment for youth referred from Neon Street. The emergency room sees about 20 youth a month from Neon Street, only about three of whom have private insurance or Medicaid; the rest are seen free of charge.

The Emergency Services Department will provide most types of medical care and will admit patients who need additional treatment (including those in labor) to the hospital. Most of the treatment provided is for respiratory and gastrointestinal disorders. The hospital's outpatient clinic also will provide free care to Neon Street youth, but both the hospital and Neon Street staff agree that the three-week wait for an outpatient appointment deters youth from getting care. The outpatient department does not take walk-ins. Two services that the hospital is able to provide only to insured youth are psychiatric and substance abuse services. Also, the hospital does not do HIV testing, but refers youth to testing clinics.

In addition to its agreement with Illinois Masonic Hospital, Neon Street also accesses health services through the Health Care for the Homeless Project (HCHP) in Chicago. HCHP, which is funded by federal Stewart B. McKinney Act, city and state funds, provides two nurse practitioners to Neon Street Center once a week. Most of their time is spent providing health education, including AIDS education, family planning, health maintenance, and pre-natal care in conjunction with Illinois Masonic Hospital's OB/GYN services. Neon Street is the only adolescent site in Chicago served by HCHP, which provides health services to about half of the city's adult shelters as well.

* * * * * * *

Most street youth who frequent **The Storefront** in San Diego are not willing to utilize the medical services available at a nearby adult shelter, nor do they use a local EPSDT-certified free clinic. Determined to provide on-site preventive and diagnostic care, which would enable teens to develop a trusting relationship with a stable cadre of physicians, The Storefront linked up with

Project Concern International, an organization that recruits physicians and nurses to serve as volunteers in Third World countries.

Through Project Concern, The Storefront recruited a gynecologist, pediatrician, ear, nose and throat specialist, family practitioner and nurse who provide medical care one night a week at the shelter. A fully equipped doctor's office with an examining table has been set up with donated equipment. Revenues from a state tax on cigarettes provide fees for laboratory work and prescription drugs.

Storefront staff not only emphasize the importance of health care at group meetings and individual counseling sessions, but work with each teen to overcome the formidable barriers to obtaining a MediCal (California's Medicaid insurance) card. Obtaining the card requires a birth certificate (which some states refuse to send through the mail), as well as an identification card with a photograph. Once the necessary documents have been secured, there is a three-month wait until a card is issued. This long waiting period, which obviously discourages transient youth from applying, makes the availability of free on-site care more urgent.

HOUSING

Issues

The lack of housing alternatives was cited by virtually every program we visited as one of the most critical unmet needs of the populations they serve. As discussed earlier, the Runaway and Homeless Youth Act, first adopted in 1974, did not envision a diverse population of multi-problem adolescents who would require a range of housing options.

Youth workers described several populations that they encounter frequently, who require creative, new housing options: chronic street youth, who have been away from home for at least six months and for whom family reunification is unlikely; "throwaway" youth, for whom reunification also is not an option; youth who have fled abusive, dangerous home situations; so-called "system" youth who have been ejected or rejected by traditional child welfare and juvenile justice agencies; and, many older, 18- to-24-year-old homeless adolescents with histories of

substance abuse, mental illness and prostitution. Within each of these populations, there are subgroups—such as teenage mothers and their babies, homeless youth who are HIV positive, gay and lesbian youth and non-English speaking youth—who have additional service needs.

Observers predict that escalating poverty will cause the population of multi-problem older adolescents requiring a range of housing options to increase in the next decade (Select Committee on Children, Youth and Families, 1989). In addition to poverty, another cause of the swelling population of homeless youth is that they often are denied admission to mental health and substance abuse residential treatment facilities, and to traditional foster and group homes through the child welfare system. Residential treatment facilities often impose requirements that disqualify homeless youth. For instance, some facilities deny admission unless families are involved; substance abuse facilities often reject youth who are taking psychotropic medication; mental health facilities often reject youth who are actively involved in drugs; and, some facilities are restricted to taking only youth who are clients of the child welfare or juvenile justice systems.

Similarly, the foster care system, overwhelmed as it is with younger children and infants, is disinclined to assume responsibility for older youth. Youth who have suffered long-term chronic neglect or psychological abuse are turned away, not because child welfare workers are unaware or unsympathetic to their plight, but because there are no resources available, especially for older youth.

Even when runaway and homeless youth programs have access to the child welfare system or have created successful voluntary foster home networks, traditional foster care and group homes are not models that work very well for older youth. Chronic street youth, who have been on their own for some time, essentially want independence; while they may desire family ties, they do not want to be parented, nor are they able to accept the expectations and structure inherent in foster care. Many of these youth already have been in foster care at younger ages and have been returned home as adolescents, only to be returned once more to child welfare for placement. Youth who have been through this cycle find it hard to adjust to yet another foster care

experience. Transitional and independent living models, with support services, seem to be more successful with these youth, in the experience of the programs we visited.[9]

In some areas of the country, such as Washington State for example, state child welfare, child mental health and juvenile justice policies have shifted away from residential components in favor of less restrictive service components, such as day treatment and family preservation services. While such policies have emerged from the positive goals of keeping families together and keeping children out of often inappropriate, restrictive state institutions, another result has been a reduction in the number of funded residential and group home beds, which has further restricted the housing options for runaway and homeless youth.

During the late 1970s and early 1980s, federal and state policy promoted the "deinstitutionalization" of troubled youth and the "decriminalization" of status offenders. Although this was an encouraging policy trend, it was implemented without a concomitant increase in community-based facilities to replace the institutions that formerly housed these youth. Without resources to help them (or to rebuild their families), many of these formerly institutionalized youth have become homeless (Kamerman and Kahn, 1989). As a result, in some cities that we visited, such as Des Moines, there is a shortage, not only of transitional housing, but also of short-term emergency shelter for teenagers. Des Moines has only 15 emergency shelter beds for "non-system" youth. The result is that "non-system" homeless youth who seek shelter are frequently turned back onto the streets.

In response to the housing needs of this diverse population of youth, providers have begun to expand their emergency shelter options and to develop various types of alternative long-term housing components. This is a relatively recent phenomenon among runaway and homeless youth service providers. While all of the programs we visited have now developed at least one longer term housing component, most are less than four years old.

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[9]In 1988, an amendment to the Runaway and Homeless Youth Act authorized grants to establish and operate transitional or independent living programs for homeless and runaway youth. However, the current funding level of $9.9 million falls far short of meeting the need.

Because youth with special needs require housing and support services tailored to their particular life situation, no one housing model can possibly encompass the diversity of homeless youth. The programs we visited describe a need for a continuum of housing arrangements, ranging from the most protective and structured to the most independent. These include: emergency shelter;[10] longer term shelter; therapeutic residential programs; transitional housing; cooperative apartment living; independent living (with follow-up and aftercare services); and, home ownership for young adults. The programs that are attempting to develop this kind of continuum are finding it an expensive and complex undertaking. They face a number of common barriers:

- The severe shortage of low-income housing and affordable apartments makes it difficult to locate housing components in safe neighborhoods;
- Neighborhood and landlord resistance to non-traditional residents has intensified in the last few years, partly due to the increase of violence, drugs and homelessness; and,
- A proliferation of group homes and other housing arrangements for needy populations has produced not-in-my-back-yard ("nimby") protests in some cities.

Even when facilities are found and community acceptance obtained, program staff expressed hesitancy about their capacity to navigate the financing, staffing and program elements of these new housing projects. In particular, they are concerned about:

- The difficulty of finding a secure source of funding once start-up monies are depleted;
- The challenge of finding, training and retaining live-in staff;
- The problem of acclimating street youth to a structured housing environment;
- The length of stay required to bring about significant behavioral change and a realistic chance for independence;
- The inadvisability of mixing younger, naive adolescents with street-hardened older youth; and,

[10]This section discusses issues and viable strategies related to housing, but does not include emergency shelter, which is discussed in the next section.

- The difficulty of defining and evaluating effectiveness.

For virtually all of the programs we visited, housing remains an area of experimentation, but one in which it is becoming increasingly necessary to venture.

Viable Strategies

Bridge House in Boston is a 9- to 12-month transitional program, serving 16- to 21-year-old homeless youth, male and female. The program is housed in a 16-bedroom facility that was once a church rectory, which is leased to **Bridge** by the Archdiocese of Boston for one dollar a year. The program began in 1982 with a grant from Act Together, Inc. and later was refined and adapted with support from the U.S. Department of Health and Human Services.

Following is an excerpt from recent testimony given by the Clinical Director of Bridge before the U.S. Senate Subcommittee on Children, Family, Drugs and Alcohol in February 1990 describing Bridge House:

> The Bridge Independent Living Program provides transitional living for street youth 16-21 years old. The house is available to youth who express a desire to leave street life behind and move towards independent living.
>
> All youth at the Independent Living Program must agree to attend school, work a job, be involved in managing the house, take turns cooking and shopping, receive counseling, and participate in group activities. They must abide by house rules which prohibit sex, drugs, alcohol or weapons in the house, dictate curfews, and require that youths avoid Boston's downtown centers for street life. Youths share rooms, decorated to their tastes, and share a common kitchen, dining and living room area. A mandatory weekly group meeting for residents serves as a vehicle for conflict resolution, development of communication skills and provides an opportunity for interpersonal feedback and for insight into themselves.
>
> The [Bridge House] offers young people 9 to 12 months of housing in a supervised setting; training in independent living skills; medical screening, evaluation and treatment; psychological evaluation and treatment, which emphasizes issues of sexual abuse, sexuality, prostitution, drug and alcohol abuse, depression and self-esteem; and job development.... Youths open savings accounts and pay $50 rent per week....

> The program is staffed primarily by a project coordinator who has overall responsibility for case management, coordination of clinical services, and supervision and training of counselors and volunteers, and by seven counselors who are responsible for 24-hour coverage of the house.... A licensed psychologist provides consultation. The service portion of this program, which can house 16 youths at a time, costs approximately $300,000 per year.
>
> Much of the success of the program can be attributed to the creation of a strong family atmosphere in which youth are both valued and challenged to succeed .... Fewer than 20% of the 45 youth annually who reside at the Independent Living Program return to street life.
>
> (U.S. Senate Subcommittee on Children, Family, Drugs and Alcohol, 1990.)

Bridge has chosen not to accept Department of Social Services (DSS) funds for Bridge House. The reasons for this are twofold: (a) the house was designed to serve homeless youth; and, (b) Bridge prefers to maintain an open intake policy to ensure that youth not served by the "system" have access to the program.

Bridge House residents adhere to a schedule for regular group sessions and for meals, including at least one weekly "big meal", such as a Sunday dinner; each youth has a schedule incorporating work, education, counseling and other activities. Each youth's schedule is followed closely by program staff; as one staff person said, "We know every job supervisor of every one of our youth, and we do job counseling. We are in constant communication with other Bridge components in which our youth may be involved, such as substance abuse counseling, and we keep in touch with Bridge's street outreach workers to make sure we are on top of what is going on on the street."

Unlike many traditional youth group homes, Bridge does not use "contracts" with youth to modify behavior, believing that contracts based on a threat of expulsion are too restrictive and create resentment. Instead, the program incorporates an "unconditional care" philosophy. Every conceivable attempt is made to keep youth a part of the program. Bridge House is not without rules, however; it has clear, straightforward standards, such as a prohibition against drugs or weapons. Staff respond to infraction of these standards as would parents in a nurturing family, who would not "kick out" a youngster that misbehaves. Bridge House also does not use a point,

level or demerit system, believing that their youth, who are struggling with many issues of self-esteem, do not need to be evaluated publicly nor to compete with one another.

Bridge House staff recognize that many of the youth they serve enter the program feeling depressed, lonely and alienated from "normal" life situations of home, school and community. Therefore, Bridge House tries to create as normal a home setting as possible, paying attention to the seemingly small traditions that characterize family life, such as encouraging festive celebrations of holidays and birthdays, a weekly "big meal" and frequent interaction with friends and family members. Through its emphasis on teens' working, attending school, paying rent and participating in house activities, Bridge House tries to create many opportunities for success.

Bridge House hires staff who have had prior experience with youth, who are nurturing and non-threatening. Nurturing male staff are particularly valued, as many youth either have had no male role models or only those that are very dominating. Because half of the youth served are minority, mainly African Americans, Bridge is increasing its efforts to hire African American male staff. All Bridge staff receive training in how to set limits with youth and in AIDS and substance abuse issues.

Similar in philosophy to Bridge House is the *Single Parent House,* opened in 1989, which provides nine to 12 months of transitional living for young mothers, ages 16 to 21, and their babies from birth to three. The program, which can house eight mothers and their babies, has a staff of four full-time residential assistants, one half-time assistant and one coordinator.

Mothers involved in the program participate in Bridge Family Life Center, a day program that provides individual counseling to pregnant and parenting youth, most of whom have histories of physical abuse, sexual abuse and substance abuse. The Center also teaches parenting skills and provides day care for mothers involved in other Bridge components, such as the education/pre-employment component where youth study for their General Equivalency Degree (GED). Both the Single Parent House and the Family Life Center are designed as early intervention initiatives for mothers at high risk of perpetuating abusive patterns. At the Single Parent House, many of

the mothers are working, and all are involved in developing community networks, housekeeping, weekly group sessions and other Bridge components.

Bridge's *Cooperative Apartments,* another new housing component, opened in 1989, to house youth who have been through Bridge's other residential programs. Youth lease the apartments for one year and share apartments in groups of two to four. The Cooperative Apartments are staffed by a one-third time residential coordinator and one-third time residential assistant, who visit the apartment residents weekly and conduct weekly group sessions. After a year, youth move to independent living, but continue to have access to aftercare services, if needed.

Bridge's Board of Directors was actively involved in finding the three-building facility for the Single Parent House and the Cooperative Apartments, arranging financing to purchase it and developing funding and in-kind support to renovate it, including Stewart B. McKinney Act funds and DHHS monies. They also were active in legal and public relations efforts to overcome community resistance to the home.

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Casa Nor Este in Albuquerque is what **Youth Development, Inc.** (YDI) calls a "mid-level stay shelter" for chronic runaway youth under age 18. The program, which opened in 1986, is used as a longer term housing option for youth who require more than two weeks or 30 days of emergency shelter. Although youth can stay up to six months at Casa Nor Este, the average length of stay is about four months. Casa Nor Este is a 12-bed facility, serving both males and females. The program operates in a state-owned house that has been leased to YDI for $1 a year.

Casa Nor Este has a high staff ratio that includes 24-hour supervision provided by a director, two Master's level supervisory counselors and five B.A. level house staff, who have backgrounds in special education, recreation, psychology and youth services.

Youth living at Casa Nor Este attend school or are enrolled in YDI's GED component and have jobs. Chapter I monies fund on-site computer-assisted learning for GED preparation and independent living skills. Rules of the house are similar to those of Bridge House, including no drugs, alcohol or violence.

From Casa Nor Este, youth move into independent living, return home, or enter a state program, such as a group home, foster care or residential treatment center. YDI provides follow-up and aftercare for six months.

YDI is in the process of purchasing U.S. Department of Housing and Urban Development (HUD) repossessed housing (small two-bedroom houses and apartments) to provide housing for young pregnant women, young parents and their babies, who are either homeless or living in untenable family situations. YDI has a grant from HUD and the City Housing Authority to purchase and remodel the housing and to provide support services. Rents will be subsidized through HUD's Section 8 program.

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Neon Street in Chicago opened *Neon Dorms* in August, 1988. It is a 12-month, 35-bed transitional living facility, serving 18- to 21-year-old homeless male and female youth. Neon Dorms is unique among the housing components we visited in that its structure resembles a college dormitory or an adult shelter more than it does a group home. The Neon Dorms facility is a "safe place" for homeless adolescents to sleep, offering an important alternative to the typical inner city adult shelter where many homeless youth feel neither safe nor welcome. The facility opens at 8:30 p.m. and closes at 9:00 a.m., much like many adult shelters. However, unlike most adult shelters, Neon Dorms requires its residents to attend the day program at Neon Street Center and to work or attend school 20 hours a week.

In addition to a job or a school program, youth at Neon Dorms must have identification (birth certificate, Social Security card, driver's license or Illinois State identification card) and a medical evaluation—all of which Neon Street staff will help them to obtain. Also, to stay at the

Dorms, youth must go through intake at Neon Street Center, which provides an individualized service plan.

A typical schedule for youth staying at Neon Dorms is:

7:30-8:30 a.m.	Wake up, Dorm chores, breakfast
9:00 a.m.-3:00 p.m.	Work or school
After work or school	Group sessions, individual counseling, recreation activities, etc., and dinner at Neon Street Center
8:30 p.m.	Return to Dorms in Neon Street van
9:00-11:00 p.m.	Activities at Dorms.

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YouthCare in Seattle operates two transitional living programs: 1) *Threshold,* serving 16- to 18-year-old emancipated females who have a history of sexual abuse and are involved in or at risk of prostitution; and 2) *Straley House,* serving 18- to 21-year-old male and female homeless youth.

In philosophy and structure, Threshold, begun in 1986, was modelled after Bridge House in Boston, which provided technical assistance to the Seattle program. Additionally, Threshold based its program philosophy and service delivery on the recommendations in Boyer's Street Exit Project, a two-year study of youth involved in street life and prostitution (Boyer, 1983). Boyer found that several programmatic features were essential to helping youth exit street life. These include: a safe, stable place to live; a stable source of income; effective role models; and, some resolution of family issues.

Young women must be referred to Threshold by the state child welfare system and must be in state custody. However, YouthCare has developed a relationship with the child welfare system that allows for "give and take" regarding referrals. YouthCare can question the appropriateness of the state's referrals and also can request that a youth be referred to the program who is not yet in state custody.

There are three phases to the Threshold program. In Phase I, young women spend two to four months in YouthCare's shelter program, called The Shelter, for "stabilization and assessment". At the Shelter, where there is an emphasis on external structure, youth are required to abide by specified rules, a schedule for meals and activities and a curfew. Youth must attend school or work (or both) and must establish a bank account. Phase I emphasizes in-house skill training, which includes learning how to live cooperatively and how to assume responsibility. Four beds at the Shelter are set aside for Threshold participants.

In Phase II, youth move to Threshold House, a four-bed home staffed with one live-in foster parent and two full-time youth workers. There is much less imposed structure in Phase II. Residents are encouraged to develop their own internal standards of behavior and to share responsibility with staff for cooking, shopping and cleaning. At this phase, the program operates more like a family home than a group home. Youth participate in a weekly group meeting, must attend school and have a part-time job. Residents do not pay rent, but (like the Iowa model) two-thirds of their income is put into a special account and returned to them when they leave the program to assist with independent living. Youth stay in Phase II from three to eight months, depending on their individual needs.[11]

In Phase III, young women move to independent living, with help from Threshold staff in finding apartments and roommates. Staff also help clients to access emergency assistance to help pay their first month's rent. Intensive aftercare services are provided, including weekly meetings with case workers. Most youth are involved in Phase III for six months to one year.[12]

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[11]Attached at Appendix D is a fuller description of the Threshold program that includes house rules and program guidelines that were developed with assistance from youth in the program.

[12]It is interesting to note that, while all of the programs we visited provide and cite the critical importance of aftercare services, few funders pay for aftercare. This is also true of the Threshold program.

Of the 24 young women who have "graduated" from Threshold in the last three years, 90% have high school diplomas or GEDs and eight are enrolled in community colleges. Two are on public assistance and eight have returned to street life.

YouthCare's other transitional facility, Straley House, is a new component begun in October of 1989. Currently an eight-bed house, it is being remodeled to accommodate 12 youth. The program serves both males and females (on separate floors), 18 to 21 years old. Most youth come to Straley House from Orion Center, which is YouthCare's drop-in center, or from other youth services agencies.

Since Straley House residents must help defray the cost of their stay, they must have a part-time job or be looking actively for one (with staff support). Residents contribute 10% of their earnings or $60 a month, whichever is less, to offset costs. Additionally, two-thirds of their income is put aside for independent living. Youth share with staff the responsibility for housekeeping, shopping and cooking and participate in a weekly group meeting and in substance abuse and AIDS education groups.

Staff at Straley House include: one house manager, three youth workers who are on a rotating shift basis, and one Master's level caseworker who is responsible for treatment planning, counseling and community liaison.

The Straley House is funded with a combination of Stewart B. McKinney Act funds, HUD dollars, city monies and private donations.

YouthCare employs a part-time, Ph.D.-level clinical psychologist, who provides supervision to all of its residential programs. He provides five hours a month of consultation to staff that includes individual case consultation, staff training, advice regarding milieu therapy and assistance with integrating new staff. YouthCare (like the other programs we visited) expressed an increased need for clinical expertise, especially in the past few years, as the mental health problems of youth and demands on staff have become increasingly severe.

* * * * * * * *

The Iowa Homeless Youth Center (IHYC), which opened in 1990, provides up to two years of transitional living for eight youth between the ages of 16 and 21. Located in a residential neighborhood, the program occupies a clapboard two-story house that looks (from the outside) similar to the other single-family homes in the neighborhood. Since the project is in an area with many abandoned dwellings, the neighbors were actually pleased to learn that the house would be occupied by IHYC.

The Iowa Homeless Youth Center received two federal start-up grants (a five-year Stewart B. McKinney grant and a two-year grant for transitional living services from the U.S. Department of Health and Human Services). These monies enabled IHYC to purchase and remodel its facility and to hire additional staff.

The original mission of IHYC was to provide long-term housing for street-hardened, "non-system" youth. In fact, IHYC's residents are mostly recent runaway youth who have been through numerous treatment programs and foster care placements, have finally been rejected by the child welfare system, but have avoided street life by living a precarious existence with relatives or friends. "Our program is too structured for hard-core street kids," a staff member explained. "We are really preventing kids from living on the streets by providing them with a last-ditch alternative."[13]

IHYC is staffed by a Program Coordinator, three full-time counselors (a drug counselor, a transitional living counselor and an independent living counselor) a secretary, a Facility Coordinator (who provides group and individual therapy), and a live-in house parent. The program is further enriched by an array of "adjunct staff" including: part-time house parents; Board Members; a Doctoral student from Drake University, who co-leads the weekly therapy

[13]IHYC serves hard-core street youth through the efforts of its two Outreach Workers who comb the streets of Des Moines nightly in the IHYC van offering emergency food, clothing, medical care and counseling.

group; a Youth and Shelter Service's (YSS)[14] Outreach Director, who leads a weekly case conference reviewing the status of each resident and providing administrative supervision to the Program Coordinator; and, a YSS psychologist who provides evaluations of each resident. In addition, YSS bookkeepers and auditors take care of budgetary and fiscal records. IHYC's 1990 budget of $283,390 (which includes its independent living apartment program) reflects, not only the relatively low cost of living in Iowa, but also the advantages of sharing program costs with YSS.

Youth at the Iowa Homeless Youth Center have their own small bedrooms and bathrooms. A buzzer on each bedroom door notifies the house parent if the door is opened after 11:30 p.m. on week nights and 1:30 a.m. on weekends when residents are expected to stay in their own rooms. During the daytime hours, each youth attends school (some are enrolled in the local high school; others attend a half-day alternative high school or GED program); most have after-school jobs. Work is mandatory for all IHYC residents; during summer months, most youth work full time.

IHYC regulations and expectations are delineated in the Resident Contract (see Appendix E) that each youth signs when entering the program. Unlike Bridge House, IHYC does not utilize "unconditional acceptance" to influence behavior. All residents sign a contract that begins with:

> I further agree to obey the law, stay chemical-free, keep appointments on time, and cooperate with the Homeless Project Staff, my Probation Officer or Social Worker (if applicable) as part of this contract. I understand that this Resident Contract will also serve as a lease and that I am hereby entering into a landlord-tenant relationship with the Iowa Homeless Youth Center.

Other requirements include: developing a detailed budget and keeping careful expense reports; placing half of all income (after monthly expenses) into a savings account to be used as security deposit on a future apartment; using food stamps to purchase groceries; paying IHYC an agreed-upon fee as rent on the first day of every month; paying an initial damage deposit; and, arriving on time for all appointments.

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[14]YSS is the parent organization of IHYC.

With the exception of four major sanctions (no sex, drugs, violence or use of weapons), infractions of a youth's contract does not result in immediate termination. However, the expectations outlined in the contract serve as a guide for evaluating progress and a youth's readiness for privileges and independence. Every two weeks, when client and counselor review a client's treatment plan, in weekly Independent Living Skills Group, in therapy group and in individual counseling sessions, the rules and expectations outlined in the contract are challenged, examined and discussed. Over time, IHYC residents are helped to accept and live within established guidelines (or, eventually, to accept the consequences). The goal of this socialization process is to lead IHYC's young residents toward maturity and independence. Because socialization is a slow process, residents can stay at IHYC for as long as two years.

Typically, when youth first come to IHYC, they are eager to move out of the house and into their own apartments. The realities of independence discussed in the mandatory Living Skills Group help to change naive enthusiasm into sober reticence. "Usually after they've been here for six months, they go through a period of not wanting to leave; then, we have to be careful not to hold on too long, but not to send them out too soon," a counselor explained.

In Living Skills Group, IHYC residents learn practical skills, such as how to open a bank account, find and apply for a job, qualify for college, find an apartment, and clean house, as well as more subtle skills, such as how to avoid being exploited by employers, landlords or boy friends. "Our kids have been exploited so often in their lives, they've gotten used to it," a counselor explained.

The criteria for moving from the transitional living program to an apartment include: meeting the requirements in the Resident Contract; doing well at school and at work; handling money responsibly; and, finally, being able to think realistically about the future and make good choices in the present. When youth have achieved these objectives, they look for an apartment with the help of a counselor. Throughout this process, the counselor is able to help the youth learn to make responsible decisions. IHYC provides furniture and, initially, pays the rent on the apartment; the resident pays for utilities, clothes, transportation and other necessities. Youth in the apartment program must continue to put 50 percent of their income into a savings account,

to attend the independent living group, and to meet with their counselor. As their income increases (usually this occurs after graduation from high school), they begin to assume increased responsibility for the rent. IHYC is willing to continue subsidizing rent as long as there is genuine need for this extra assistance. Occasionally, a youth will be forced to move out of an apartment and return to IHYC. This is not considered a failure, but, rather, an opportunity for further growth.

At present, IHYC can accommodate seven youth in its independent apartment program. Discussions are underway, however, between IHYC and the Des Moines Department of Social Services for additional independent living apartments to house child welfare system clients as they age out of group homes or foster care. In Des Moines, as in all the cities we visited, there is a desperate need for transitional, subsidized independent living apartments for older adolescents.

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San Diego Youth & Community Services (SDYCS) opened the *Bridge,* its first runaway shelter, in 1970; its second home, the *Gatehouse,* was opened eight years later in El Cajon, a low-income, single-family community in San Diego county. The two short-term group homes, which shelter a total of 14 teenagers, ages 12 to 17, provide intensive treatment for youth who are referred by the police, by the Department of Social Services, and by parents, as well as for self-referred walk-in clients. There is always a waiting list for space at the two houses, which admit a total of 260 youth each year.

The Bridge and the Gatehouse provide more for clients—and expect more—than a shelter. After completing a detailed intake interview, residents are introduced to a Value and Level System, which encompasses the house rules and expectations. The system has five cardinal values that the staff use to assess behavior: Caring for Others ("expresses personal feelings without attacking or judging"); Responsibility for Self; Honesty; Fairness ("accepts differences between individuals"); and, Forgiveness ("recognizes that people do the best they can with what they have at the time"). Demonstrating these values enables residents to move from Level 0 "Space Takers"

to Level IV "Leaders". Each level brings an increased array of privileges, including longer passes, attendance at staff meetings, increased allowance and use of the radio and telephone.

Bridge and Gatehouse residents must demonstrate their ability to use freedom responsibly. In daily community meetings, residents examine their own and each other's behavior and feelings. A youth who spends four consecutive days at Level 0 ("violates major program values and has shown no progress") earns the right to leave the group home (see Appendix F).

The two group homes have four major funding and referral sources: the Department of Social Services (DSS), the Community Action Program (CAP), Family and Youth Services Bureau and United Way. Teens referred by DSS may stay for as long as 90 days (some stay even longer while awaiting placement). CAP-referred youth may stay no more than 14 days, however. Staff are deeply troubled by this discrepancy in length of stay, which requires SDYCS to terminate CAP residents before substantive changes can be made in the home environment. "In the two weeks they are with us, we do our best to teach kids how to escape from abuse, and whom to call for help if they are being hurt. We need to keep them for at least six months to make real changes," the Coordinator explained.

In the short time that youth spend at the Bridge and Gatehouse, milieu therapy (as defined by the Value and Level System) and family therapy are the major treatment modalities. At least four sessions of family therapy occur while a youth is at the home. Often these sessions are held in the family home. While their child is at the group home, parents are usually willing to participate in family therapy. However, staff reported that very few families take advantage of the six months of follow-up care, including eight additional family therapy sessions, that the program offers.

Even though family therapy sessions are careful to indict neither parents nor youth, parents sometimes refuse to take their adolescent back home. If there are no beds available at San Diego's Receiving Home, police insist on attempting to return the youth to the family. Not infrequently, parents continue to refuse to allow their child to stay at home. At this point, the youth is homeless; many youngsters who are ejected from home in this way seek shelter at The

Storefront, the SDYCS emergency shelter. Thus, even if a short stay at the Bridge and Gatehouse cannot resolve family problems, it helps residents to become aware of the resources in the community, preventing some youth who are forced to leave home from ending up on the street.

EMERGENCY SHELTER

Issues

A 1989 study of 44,274 homeless and runaway youth concluded that providing for the *long-term needs* of today's youth within the 15 days of shelter allotted under terms of the Runaway and Homeless Youth Act is difficult, if not impossible (U.S. General Accounting Office, 1989).

Of the seven sites we visited, several provide traditional emergency shelters. One provides emergency shelter using a modified adult shelter approach. Others offer "host families" with whom youth can stay for two or three nights; and, most work collaboratively with other local shelters, often sharing clients and resources. In all cases, emergency shelter is only one component in a much broader spectrum of longer term services.

Although the need for emergency shelters has increased, youth workers told us that 15-day shelters often create as many problems as they solve. For example, mixing vulnerable, younger 12- to 14-year-old "baby runners" with older street-hardened teens can result in youngsters becoming indoctrinated or exploited by sophisticated older adolescents. Emergency shelter can perpetuate street life by giving youth a temporary respite, but not providing adequate time for services that can change behaviors. As a practical matter, youth easily circumvent the 15-day shelter limit, either by cycling back and forth between the street and the shelter or by jumping from one shelter to another (the so-called "shelter shuffle").

While emergency shelters for youth may have their own set of problems, the shortage of youth shelter beds that exists in every city creates a larger concern. With no where else to turn, street youth often utilize adult shelters, many of which provide only temporary help, such as food and a cot, thus enabling teens to continue living on the street.

Several of the programs we visited have begun to collaborate with adult shelters, setting up referral mechanisms to divert youth to more appropriate resources. However, in some cities, tensions have developed between homeless advocates and youth advocates over shelter services for homeless adolescents.

In Chicago, the Coalition for the Homeless, concerned over the large numbers of homeless youth using adult shelters, successfully lobbied for passage of state legislation to allow homeless providers to create shelter beds for youth, ages 14 to 21. Youth advocates were initially opposed to this legislation—and many are still ambivalent about it. According to youth advocates, the new law requires only minimum health and safety standards for licensing youth emergency shelter beds, and it does not require services that youth advocates insist are needed to empower youth to exit street life. In addition, advocates argue that the legislation further absolves the child welfare system of its responsibility for homeless youth. Homeless advocates, on the other hand, counter that child welfare is so overwhelmed that it cannot assume responsibility for homeless youth; they argue that the emergency shelter legislation provides for at least a minimum level of care and an alternative to adult shelters. Homeless advocates also support the legislation because it provides legal protection for adult shelters that admit unaccompanied minors.

A "danger" inherent in the Illinois legislation is that it has the potential to add yet another service delivery system for runaway and homeless youth to a service environment that is already badly fragmented. There are already several systems involved in services to runaway and homeless youth: the public child welfare system, which has responsibility for abused and neglected youth to age 18; the so-called "1500" agencies created by state statute in 1980 in response to the de-institutionalization of status offenders, which provide emergency shelter, crisis intervention and family reunification services for runaway youth to age 18; alternative runaway and homeless youth programs of the kind described in this monograph; adult homeless shelters; and, now, as a result of the new legislation, possibly another network of providers.

Conflicts between adult and youth-serving agencies for the homeless are not unique to Illinois. In Seattle, for example, the State Attorney General recently ruled that an adult shelter

can admit youth without being licensed as a youth shelter and does not have to notify parents before providing emergency shelter to homeless youth.

Viable Strategies

The Storefront in San Diego, which admits youth between the ages of 12 and 18 (including teens with infants) has a rather unique shelter program. It has extended the traditional 15-day emergency shelter model in response to the long-term needs of its principal population of sexually-exploited youth. Like residents of more typical 15-day shelters, all Storefront youth are eligible for the following services: case management, independent living assistance, food, showers, laundry facilities, personal hygiene items and referrals to other agencies. This, however, constitutes only Phase I of the program, which extends, not for 15 days, but for only three consecutive nights. Phase I is an opportunity for wary, sexually exploited youth to "check out" The Storefront and its staff.

To make the transition to Phase II which provides comprehensive services and requires commitment from youth, youth must complete Phase I and return to the street for at least three nights. During this "time out", a youth is asked to make the commitment to exit street life that is necessary for participation in Phase II, which may extend for 90 days or more. However, teens also have the choice of returning to the shelter for an unlimited number of Phase I stints.

Many youth who do finally commit themselves to Phase II require repeated cycles in and out of Phase I before deciding to exit street life. For youth who choose to participate in Phase II, The Storefront offers a comprehensive array of services, including transitional housing, education, individual and family counseling, AIDS and drug counseling, job coaching, independent living, survival skills training and health care.

In Phase II, youth complete a lengthy intake form and are assigned a case manager with whom they meet regularly; a case plan is developed, goals specified and, if appropriate, meetings with family members are scheduled. Once youth are in Phase II and successfully working toward their goals, they may stay in the shelter until admission to the Job Corps, alternative housing or

a viable means of financial support has been secured, even if this requires a stay of six months or more to avoid a return to street life.

Unlike many other youth shelters, The Storefront is not prevented from retaining youth beyond 15 days, since its principal funding source is the California Office of Criminal Justice Planning, rather than the federal Runaway and Homeless Youth Act.

Each youth's length of stay is evaluated weekly by Storefront staff and other consultants at case conferences. These client assessments ensure that length-of-stay decisions are based on individual needs; for example, a vulnerable, emotionally disturbed 13-year-old may be allotted as much time at the shelter as is required to find a suitable placement.

Since The Storefront has only 15 beds, with five additional beds for use in crisis situations, the long-stay placements limit the number of spaces available for emergency shelter. If more than 15 teens request emergency shelter on a given night, The Storefront's Policies and Procedures Manual specifies criteria for use of the five crisis beds that are based on the program's concept of which youth are most vulnerable on the street. The criteria include: (1) youth 16 years old and under; (2) pregnant teens; (3) teens with children; and, (4) youth with mental or physical disabilities or injured youth. The Storefront's residential counselors must obtain approval from senior on-call staff (such as the Program Manager) before admitting youth to the crisis beds.

There is one additional situation that justifies filling a crisis bed at The Storefront: if a particular youth with whom the street outreach team has been working finally decides to try out the shelter for a night (even after the 6:00 p.m. intake deadline has passed), the youth can be admitted to a crisis bed. This flexibility gives outreach workers an important opportunity to build trust and enhance their reputation on the street.

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Youth Development, Inc. (YDI) in Albuquerque has operated an emergency shelter for runaway and homeless youth, ages 12 to 17, since 1976. Called *Amistad,* it is a 12-bed facility,

housing six females and six males. Amistad is a crisis facility with the goal of family reunification, although it has been increasingly difficult to get parents involved. Amistad, in collaboration with the National Coalition of Hispanic Health and Human Service Organizations (COSSMHO) and other agencies, is in the process of developing a strategic family therapy model in an effort to improve family involvement.

The average length of stay at Amistad is 14 days; however, because Amistad receives its primary funding from the state and not the Runaway and Homeless Youth Act, which underwrites only three beds, youth can stay up to 30 days if they formally request an extension. The system serves about 300 youth a year. Youth are referred to Amistad by other YDI components, by the schools or are self-referred. The program has a 24-hour crisis capability and utilizes 12 staff working three shifts of 8:00 a.m. to 4:00 p.m., 4:00 to midnight, midnight to 8:00.

From Amistad, youth either return home, move to YDI's transitional living facility (*Casa Nor Este*) or are placed in a group or foster home, although there are long waiting lists for foster and group home placement through the child welfare system. If a youngster exhausts his stay at Amistad and has no place to go, Amistad will "place" the youth with another shelter in Albuquerque. YDI retains case responsibility for a youth placed in another shelter.

In addition to food and shelter, Amistad provides case management, crisis-oriented individual, group and family therapy, and AIDS and substance abuse prevention and education. Success is measured by a youth's willingness to stay in the program and comply with the service plan. Amistad believes its major contribution is to prepare youth for treatment whom others have written off as untreatable.

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YouthCare in Seattle has operated *The Shelter,* an emergency shelter, similar to Amistad, since the mid-1970s. Serving 11- to 17-year-olds, The Shelter is a 12-bed facility that is usually filled to capacity. Staff told us they turn away, on average, 30 youth a month for lack of space. Six beds at The Shelter, reserved for street youth, are funded by the Runaway and Homeless

Youth act and have a 15-day limit. Two beds, funded by the Department of Youth Services (i.e., juvenile justice), provide "continuum of care" beds, that is, as a step down for youth coming out of detention who might otherwise end up on the street; the average length of stay for these youths is three months. Four beds are reserved for girls involved in or at risk of prostitution, who are participating in the Threshold Program funded by the child welfare system.

Youth come to The Shelter as self-referrals, from other youth service agencies, the police, schools and other shelters. Like Amistad, the program has 10 staff working on a rotating shift basis, and provides a safe place, a home-like environment and crisis intervention services. From The Shelter, some youth return home or to the streets, are placed in a foster or group home (as in Albuquerque, these spaces are limited), enter Job Corps or move to YouthCare's transitional housing facilities. The Shelter serves many youth who cycle in and out of street life and shelter services.

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Neon Street in Chicago provides emergency shelter for 11- to 17-year-olds, using a 10-bed facility that resembles a college dorm. In an approach adapted from adult homeless shelters, *Neon House* does not open its doors until 8:30 at night and closes again at 9:00 in the morning. However, unlike many adult shelters, Neon House links youth to daytime services at Neon Street Center. Intake for youth at Neon House is done at Neon Street Center, where youth are assigned a primary counselor and participate in the development of a service plan and an individualized activity schedule.

About 80% of the youth at Neon House are self-referred, having heard of the program from other youth. Four beds are funded by the Runaway and Homeless Youth Act, with a 15-day limit, and six are funded by the State Department of Child and Family Services, providing more flexibility in length of stay.

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Two of the programs we visited—**Bridge** in Boston and **United Action for Youth (UAY)** in Iowa City—intentionally do not have emergency shelter facilities. Both programs instead use networks of host family homes for younger runaways and other youth shelters with whom they have cooperative agreements.

OUTREACH

Issues

In virtually all of the programs we visited, outreach was one of the first components developed. As Boyer (1988) notes, outreach is the foundation for services to runaway and homeless youth. As one youth told us, "If they hadn't come and found me over and over again, I would never have left the street."

All of the programs use a variety of means to reach out to different populations of youth in the community. These include: street work; mobile vans; community organizing; public service announcements; telephone crisis lines; information fairs; posters; drop-in centers; peer counselors; teen theatre, music and art groups; and, outreach to schools, detention centers, housing projects and the police. Most of the programs utilize a number of these strategies; most would agree, however, with one observer who noted that: "The most highly skilled outreach worker in the world is next to useless compared to another street kid.... If you can get one kid to trust you, they will bring you more kids than you can handle." (Boyer, 1988.)

Youth workers emphasize that there are different youth subcultures in the community and that successful outreach efforts must be targeted to the needs, styles and turfs of each. More than a single outreach effort is required to build in-roads into the various groups. In addition, no matter what their subculture, different styles of outreach are needed to reach youth, who: (1) will never seek shelter (and for whom the outreach contact thus becomes an end in itself); (2) can be convinced over time to seek shelter; and, (3) can be deflected from street life.

Staff indicated that drop-in centers and street work programs, often involving a van, entail the most complex and costly methods of outreach. However, they also afford the most effective

strategies for reaching hard-core street youth. The success of drop-in centers and street work programs is usually attributed to three factors: first, they offer tangible services that teens want, such as food, clothing, a hot shower, safety, medical treatment or counseling, without obligation; second, such outreach programs are consistently available, allowing youth time to decide when they are ready to access services; third, outreach staff offer assistance, but suspend legal or moral judgments, in all but the most extreme situations.

Youth workers who staff drop-in centers or outreach vans are on the "front line", regularly confronting unpredictable situations that can jeopardize their personal safety or the agency's reputation. Often confronted with the most provocative youth, who repeatedly "test" their trustworthiness, the outreach workers we interviewed emphasized the importance of having written policies and procedures to assist them in making decisions that are consistent with agency values and regulations. To ensure outreach staff have the guidance and protection they need to function optimally, effective programs have policy guidelines to clarify issues that frequently cause controversy, specifically:

- **Safety.** As a result of the increase in violent and criminal teen behavior, many agencies now require outreach workers to operate in teams, even in instances of dire emergency.

- **Relationship with Police.** Those instances when staff are obligated to inform or cooperate with police officers need clarification, following discussions with local officials. Areas of the community in which outreach workers operate (or where a van parks) require permission from police.

- **Extent of Services.** Those services and supplies that outreach workers can offer must be specified, including those places to which staff can transport youth in an agency van.

- **Relationship with Youth.** Since outreach staff are frequently confronted with teens in serious jeopardy, the extent of a team's obligation to "rescue" a youth must be clarified. For instance, most programs have written policies that preclude staff from taking a youth into their own homes.

- **Documentation.** Outreach staff need confidential methods to record contacts with youth, demographic data and the services provided.

Supervision and Training. The danger of burn-out among drop-in center and street work staff is high. Confronted with difficult ethical issues and problems which can rarely be solved in their brief contact with street youth, outreach workers need regularly scheduled supervision, case conferences and in-service training.

In addition, most drop-in centers have established protocols as to how often or how long a youth can use the drop-in center before having to commit to a more substantive service plan. Programs recognize that street youth need considerable time and opportunity before they will begin to participate in services such as employment training or drug counseling. At the same time, programs want to avoid "enabling" youth to live on the street by only giving them basic services (food, showers, etc.) that do not lead to more substantive behavior changes.

Viable Strategies

Drop-in Centers

At *The Youth Center,* in Iowa City, **United Action for Youth (UAY)** does not delineate among its prevention, outreach and intervention services. The Youth Center is both a drop-in and a counseling center for Johnson County teens between the ages of 12 and 18. (UAY is flexible about its age cut-off, welcoming back older adolescents to serve as mentors or volunteers and allowing 10 to 12-year-olds to use the Youth Center.)

UAY's director, who was formerly a mime, hires staff who share his commitment to the healing powers of creativity. Youth Center staff, which consist of a Prevention Counselor and a Clinical Director (both have Master's degrees), a studio technician and three youth counselors, is composed of people who are equally competent in counseling and the arts. The ability to lead group recreation activities is another capability of most UAY staff. In addition to its artistic workshops, the Youth Center sponsors volleyball, basketball, frisbee, golf, nature hikes, camp outs, falconry and swimming events for teens at the drop-in center.

The Youth Center is conveniently located in an informal Victorian house within walking distance from downtown Iowa City. The proximity of counseling to prevention and outreach

makes it possible for a youth to drop-in to play the drums, for example, and gradually develop a trusting relationship with his "drum instructor", who is also a trained youth counselor. The drum lessons may lead to family therapy—at the same familiar location, even at the same time and often with the same staff. It is this "seamless" connection among therapeutic, artistic and recreation services that makes the Youth Center's outreach strategy unique.

UAY's drop-in center has been so successful in attracting teens that Youth Center staff no longer send street workers to shopping malls and parking lots to recruit troubled teens. As a result of its reputation on the street, as well as referrals from police and parole officers, school counselors and emergency shelter staff, the Youth Center was filled to capacity in 1989.

The Youth Center's Synthesis Arts Workshop is the drop-in center's principal drawing card. Teens come to the Center in the afternoon, in the evenings and on week-ends to use what is a state-of-the-art recording studio, with amplified keyboards and electronic instruments, video cameras, television production and super-8 animation equipment, 35-millimeter and darkroom equipment and ceramics and lithography studios. In addition, Synthesis publishes a magazine that is written and illustrated by teens, and it operates a performing drama troupe, The Dating Cellos, that produces and performs plays portraying such teen problems as sexual abuse, leaving home and shoplifting.

Virtually all of the equipment in the Synthesis Arts Workshop has been made available to UAY from the following sources: (1) outdated equipment mostly contributed by musicians; (2) funds donated from concerts held by former Synthesis Workshop participants who have become professional musicians; (3) delinquency prevention funds from the Law Enforcement Assistance Administration and the Community Development Block Grant program; and, (4) a grant from Target Stores.

In Albuquerque, **Youth Development, Inc. (YDI)** does not have a drop-in center per se. However, one YDI building, called the Tower, houses so many direct service components, many of which, as in Iowa City, are drawing cards for youth, that it has become a drop-in center for youth and families in the community. Tower programs include gang intervention, theatre and

music groups, juvenile diversion, substance abuse prevention and education, latchkey projects, recreation and outreach activities.

Unlike YDI and UAY, which target youth and families community-wide and not just street youth, the drop-in centers of the programs in Chicago, Boston and Seattle focus predominantly on runaway and homeless youth living on the street and often involved in illegal activities.

Neon Street Center for Youth in Chicago has a drop-in center, called *Neon Street Center,* that is open seven days a week from 9:30 a.m. to 8:30 p.m. (the drop-in center also houses Neon Street's administrative offices). The center provides on-site: three meals a day (youth are involved in meal planning, preparation and clean-up); shower and laundry facilities; primary counseling; medical and legal services; recreation; literacy and other educational training; prevocational services; AIDS education and prevention services; substance abuse counseling and referrals; and, transportation to and from Neon Street's emergency shelter and its transitional living facility. The center, in effect, operates as the hub of Neon Street's operations and services.

Neon Street does not limit the amount of time a youth can spend at the center on any given day. However, it does limit to 15 the number of days a youth can use the center before having to commit to a service plan and individualized activity schedule. The program director maintains that youngsters almost always commit to a service plan within the 15 days.

An intake assessment that is the basis for a service plan is not done until after a youth's fourth day at the center. According to staff, an immediate intake might seem an aggressive intrusion that could jeopardize a youth's receptivity to the program. At intake, every youth is also assigned a primary caseworker, who carries a caseload of 25 teens.

In addition to providing services and a safe haven for walk-ins, the center functions as the site of services for homeless youth who are residents of Neon Street's emergency shelter and its transitional living facility, which close during the day.

Similar to Neon Street Center, **Bridge's** drop-in center in Boston also functions as its administrative headquarters and the site of many program services. The center houses Bridge's dental clinic, substance abuse and crisis counseling services, the education component and the family life center, in addition to providing food, clothing and bathroom facilities. The center is open from 10:00 a.m. to 6:00 p.m.

Unlike Neon Street, which limits the number of days youth can use the center to "hang out", but not the amount of time on any given day, Bridge limits to 20 minutes a day the time youth can "hang out" at its center; there is no limit, however, to the number of days youth can come to the center for 20-minute visits. This rule, like Neon Street's limit of 15 days, ensures that youth do not just take advantage of "quick fixes", such as food and clothing, but will be drawn by these into substantive services.

Intake takes place at the drop-in center, where most teens come initially for subsistence requirements, such as a shower or food. It is not uncommon for youth to use the drop-in center for as long as a year before they are ready to commit to other services.

In Seattle, **YouthCare's** drop-in center, called *Orion Center,* involves a collaboration among several agencies: an education component is staffed by Seattle Public Schools; health services are provided by the University of Washington School of Medicine and the Health Care for the Homeless Project; counseling and casework are provided by YouthCare staff, who carry caseloads of 25 teens each; and, meals are provided by church groups. Orion Center was opened seven years ago as a collaborative effort to prevent juvenile prostitution in downtown Seattle. Today, Orion Center is open from 10:00 a.m. to 7:00 p.m., Monday through Friday, and it continues to focus on youth involved in street activity and to draw on the resources of several agencies.

Like all the drop-in centers we visited, Orion Center will work with youth a long time on a drop-in basis. Youth tend to stay involved in the center on a drop-in basis, on average, about six months.

Drop-in centers, like those in Chicago, Boston, Seattle and San Diego, that focus on street youth, usually discourage youth who can be reunited with their families from using the center for any length of time. With these runaway youth, staff prefer to provide crisis counseling, reunification and, optimally, follow-up family work directly or by referral, rather than the long-term engagement that characterizes involvement with chronic street youth. Also, these centers try to discourage "baby runaways", who can be influenced by harder core street youth, from using the centers.

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Mobile Vans and Street Work Projects

The Storefront in San Diego, **Iowa Homeless Youth Center** in Des Moines, **YouthCare** in Seattle and **Bridge** in Boston all have outreach vans and street workers that comb the city and outlying neighborhoods to make contact with runaway and homeless teens. Many of the strategies used by outreach workers at the four sites are similar:

- The vans follow an established route in order that street youth can depend on accessing their help at a given place and time;
- The outreach workers are skilled in crisis intervention and counseling and trained in maintaining professional calm and neutrality when confronted with difficult, dangerous situations;
- Emergency food, clothing, blankets and personal hygiene kits are distributed to street youth from the van;
- Every opportunity to provide AIDS education and prevention is utilized; and,
- Outreach workers are thoroughly familiar with agencies to which youth can be referred for additional assistance.

Although similar in many respects, each of the four outreach teams has adopted some specific strategies that are particularly effective with teens in their respective cities.

In San Diego, outreach workers from **The Storefront** began wearing identifying caps, T-shirts and jackets after a street youth was raped by a person posing as a Storefront worker. The outreach team, who walk, as well as drive, through various parks and beachfront areas along their

route, never separate during the course of an evening. The Storefront outreach worker is accompanied on his rounds by volunteer outreach staff who have been through an extensive training program and who continue to receive on-going supervision. In addition, The Storefront's Program Coordinator joins the outreach team once a month to assess their performance and to determine if any policy changes are required.

Storefront outreach workers enlist the support of local business and the police, who are encouraged to refer youth to the shelter. This public information effort (augmented by posters, printed matchbooks and public service announcements describing the shelter) is enhanced further by a beeper system. A youth in trouble or hotline operators can call The Storefront's telephone number. Staff are able to "beep" the outreach team, alerting them to the youth's location. The team then makes every effort to locate the youth and to offer appropriate assistance.

The Storefront's outreach team has five emergency shelter beds continually available for street youth who may decide to exit the street. Outreach workers also may schedule daytime hours for a particular youth to visit The Storefront for a shower, to do laundry or to see a counselor. This is another tactic for coaxing hard-core youth to "check out" the shelter before making a commitment to exit street life.

The **Iowa Homeless Youth Center (IHYC)** in Des Moines has an experienced street worker and a recent college graduate staffing its outreach van. Twice a week, they are joined by two graduate students from Iowa State University who pay street youth $2 each to complete a 10-page questionnaire (see Appendix G). Answers to the questionnaire, which are tabulated by the students, help IHYC pinpoint changes in the needs and characteristics of Des Moines street youth.

Through an interagency agreement with Broadlawns Medical Center's Homeless Outreach Project, a nurse practitioner joins IHYC's outreach team once a week to treat minor cuts, abrasions and respiratory complaints. In addition, the nurse offers counseling, evaluation and referrals for dental problems, pregnancy, chemical dependency, gastro-intestinal complaints, AIDS and mental health problems. Youth are helped to access resources in the community for follow-up treatment.

YouthCare in Seattle has done street outreach work since 1979. Initially, its street outreach workers, who operated on foot, targeted juvenile prostitutes in downtown Seattle, with the goal of getting them into appropriate services. In 1988, however, the street work program broadened its scope, becoming part of YouthCare's AIDS education and prevention project. Today, YouthCare's street workers target a broader population of youth and refer to many different services. Additionally, YouthCare now has a mobile van, modelled after that of Bridge.

YouthCare's outreach team consists of a half-time public health nurse and two full-time youth workers. Team members receive initial training that utilizes material from the University of Oklahoma's Advanced Course for Residential and Child Care Workers, and they receive YouthCare's AIDS education and prevention training, as well as in-service training and weekly supervision.

YouthCare has employed recovered addicts and peer outreach workers with some success, but stresses the importance of training and staff supervision to minimize burn-out, create stability and ensure effective service provision. Use of peer outreach workers especially requires a stable adult team, a factor which often is difficult to achieve, both because there is no stable source of funding for outreach and because turnover can be high among outreach staff. The average length of stay for YouthCare's outreach workers is one year.

YouthCare's outreach team is on the street four nights a week from 7:00 to 11:00 p.m. One night a week they are backed up by the mobile van, but parking remains a problem. At present, the outreach team is funded by the State Division of Alcohol and Substance Abuse and the federal Office for Substance Abuse Prevention.

Bridge in Boston has provided street outreach and has had a mobile medical van since its inception in 1970. The medical van is described in detail in the Medical and Dental Care section of this chapter.

Bridge's outreach team consists of three streetworkers and a coordinator (who report to Bridge's Clinical Director), in addition to the volunteers who staff the medical van. The team,

which reaches an estimated 3,000 youth a year, is funded by the State Department of Public Health. Bridge street workers are out on foot from 2:00 to 10:00 p.m., five days a week, and serve as a back-up to the medical van. Like YouthCare, Bridge emphasizes the importance of training and ongoing staff support for outreach workers.

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Community and Agency Outreach

Several of the programs we visited have developed techniques for outreach to other agencies, neighborhoods and rural areas in an effort to prevent youth from resorting to street life.

Committed to reaching teenagers at risk who live in outlying rural communities, **United Action for Youth** in Iowa City sends a team of counselors to schools and community centers within a 100-mile radius. The team conducts weekly drop-in rap and support groups, and is available for crisis intervention and counseling to teens and families, who are referred to UAY by the police or social workers. The Johnson County Board of Supervisors underwrites UAY's rural outreach program with an annual grant of $63,000.

Youth Development, Inc. in Albuquerque also provides extensive community outreach, particularly to youth and families in the barrios, to schools and to the juvenile justice system. A particularly unique YDI outreach component is *Project Poder,* funded by the City Housing Authority, to provide outreach to youth in three public housing projects and to help housing residents of all ages effect community change. YDI also organizes a wide array of intramural sports and other recreational activities; latchkey education and health promotion activities; and, music, theatre and arts activities as means of reaching at-risk youth.

As described in the juvenile justice section of Chapter VII, **YouthCare** in Seattle has a unique relationship with the juvenile justice system to which it provides outreach to divert youth picked up on prostitution charges. Both regular outreach workers and YouthCare's AIDS prevention and education staff spend upwards of 20 hours a week at detention on a daily basis, counseling youth and providing referral to YouthCare and other agency services.

At the time of our visits, **Bridge** in Boston was the only program providing daily outreach to adult homeless shelters in an effort to divert youth into Bridge services. Several programs, however, expressed the need for this kind of outreach, particularly to reach 18- to 24-year-olds.

GANG INTERVENTION

Issues

Virtually all of the programs we visited report increased gang activity in their respective communities and more gang involvement among runaway and homeless youth over the last decade. Staff report that gangs are more competitive and are recruiting at younger ages and among sub-populations of street youth that, previously, were not targeted. Gang activity places new kinds of demands on runaway and homeless youth programs, most of which have not had staff with specialized gang intervention skills. Only three of the programs we visited have gang intervention projects.

Viable Strategies

Youth Development, Inc. in Albuquerque has worked with gangs for over a decade, even though the 1988-89 fiscal year was the first time the program received funding specifically for gang intervention activities. YDI reports that Albuquerque has 44 identified gangs and 4,000 to 5,000 gang members.

YDI's *Gang Intervention Program* encompasses prevention, intervention, diversion and training activities. To prevent gang involvement and divert gang members to positive activities, YDI targets younger children, using former gang members in puppet shows and musical presentations that convey an anti-gang and anti-drug message. In recent years, as gangs have become more competitive and are recruiting at younger ages, YDI has begun to target pre-school age children, as well as elementary school children. Former gang members are involved in music, dance, art and rap groups that perform in schools, parks and community centers. YDI successfully formed two musical groups comprised of members from three competing gangs. *Voces del Barrio* is a guitar ensemble and *Just 2 Fresh* is a rap group that has won regional competitions.

To divert gangs from destructive activity to productive community (barrio) projects, YDI works with gangs on community service projects in their own barrios. In addition, YDI is doing mediation work in the schools to diffuse gang tension and violence. Youth are referred to YDI from the schools, the court system and from families. YDI has a formal arrangement with the juvenile justice system to accept court-ordered gang-involved youth in an eight- to 10-week diversion program. This component of YDI's Gang Intervention Program works with 13- to 18-year-old youth and their families, involving youth in community service projects, individual and family counseling, job training and placement, alternative education and substance abuse and AIDS education.

In addition to its prevention, intervention and diversion activities, YDI provides in-service training for teachers and school counselors. Training includes information about gangs in their respective schools and communities and the kinds of interventions that are effective in diffusing gang tension without having to resort to police assistance.

The Gang Intervention Program employs two full-time staff who are themselves former gang members from the barrios. The program is funded by federal Office of Juvenile Justice and Delinquency Prevention dollars funnelled through the state, by a grant from the federal Office of Human Development Services, Administration on Children, Youth and Families, Department of Health and Human Services (DHHS), and by the Mayor's Charity Ball.

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The Storefront's parent organization, San Diego Youth and Community Services (SDYCS), runs an ambitious gang program that reaches 600 youth annually. With a staff of 12, including ex-gang members who are employed as outreach workers, and an annual budget of $300,000, the program provides gang members with access to alternative social roles and life skills; SDYCS also regularly mediates disputes between hostile gangs. Gang members who come to The Storefront for shelter are referred to the gang intervention project.

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In Seattle, **YouthCare's** gang intervention project was initiated in 1989. It is part of a collaborative approach to gang prevention and intervention, called *Seattle Team for Youth,* that involves 24 agencies, including the police department, the juvenile justice system (Department of Youth Services) and Seattle Public Schools, as well as alternative youth services agencies, such as YouthCare. A goal of the project is to foster collaboration between law enforcement and youth-serving agencies. YouthCare estimates that Seattle has over 3,000 gang-involved youth.

Seattle Team for Youth targets 11- to 18-year-old youth who are involved in gangs or at risk. The focus of the program is to reduce gang participation, promote involvement of youth in positive activities, prevent substance abuse and provide resources for youth and their families. The resources of all of the collaborative agencies are available to the project. Four participating agencies provide outreach and case management services. There are a total of 11 case managers, two of whom are provided by YouthCare. YouthCare also provides clinical coordination and is participating in the evaluation of the project.

Seattle Team for Youth focuses on minority youth; 10 of the 11 case managers are minorities. The project's goal is to reach 300 youth a year, who may be directly referred to the program from the police, schools, other YouthCare components, parents, other agencies or through the case managers. Outreach is done primarily to other agencies, rather than to communities as in YDI's work in the barrios. Some case managers, for example, are working within the schools to build rapport with school personnel.

Individual case managers may carry caseloads of up to 30 youth, although, at the time of our visit when the project was still new, caseloads were running about 14 youth per case manager. There is some concern that, as the project becomes more visible, case managers will become overloaded.

In addition to the four agencies providing case management, six participating agencies provide specific support services. These include: values development and self-esteem building; employment and training; tutoring; mentoring; outpatient drug and alcohol treatment; and, recreation and skill building. Case managers also have access to a pool of discretionary funds, up

to $500 per youth, for services, such as transportation or emergency medical services, that are not available from participating agencies.

Seattle Team for Youth is funded by the Office of Human Development Services, U.S. Department of Health and Human Services, and the City of Seattle's Public Safety Action Program. The cost of the project is $1.3 million for two years.

EDUCATION

Issues

According to the National Coalition for the Homeless, more than 40% of homeless youth do not attend school (National Law Center on Homelessness and Poverty, 1990). In some areas of the country, where there are large numbers of homeless adolescents (in addition to children who are members of homeless families), the figure is much higher. The California Homeless Coalition, for example, estimates that 75% of the state's 33,000 homeless children and youth are not enrolled in school; this figure includes an influx of teenage illegal aliens who have entered the state from Central America (San Diego Tribune, 1989). Studies in the early 1980s of male and female teen prostitutes found school drop-out rates at about 75% (Schick, 1981; Boyer, D. and James, 1982).

Homeless youth who are not in school face double jeopardy. Since youth in adult and family shelters are required to be out of the shelter during daytime hours, out-of-school youth are easy prey to pimps, drug dealers and gang members. In addition, the longer youth are out of school, the more difficult—and the less likely—it is that they will return to school.

School attendance offers more than protection against the dangers of the street, of course. Program staff at each of the sites we visited agreed that involvement with an appropriate education program provides an essential component in the comprehensive package of services that homeless youth require to gain stability and a permanent home.

Runaway and homeless youth face numerous barriers to public school enrollment, however. Although Congress passed legislation in 1987 to exempt residency requirements for children whose families are living in shelters, emancipated teenagers are still turned away from school because they lack a permanent address, cannot meet school district residency requirements, fail to produce required school transcripts or lack immunization records. Although the 1990 reauthorization of the McKinney Act includes an amendment requiring states to remove all school access barriers, including transportation barriers, our site visits confirmed that homeless youth are being turned away from school. When the National Law Center on Homelessness and Poverty surveyed 20 states on various aspects of homelessness recently, 70% reported difficulties with school records transfer as a major problem (National Law Center on Homelessness and Poverty, 1990).

In addition to these bureaucratic school attendance barriers, which could be resolved through new federal regulations (or local resolve to "enroll the kids first, then figure out the paper work later," as one staff person put it), formidable instructional barriers prevent many homeless youth from attending school. Studies indicate—and our site visits confirm—that many youth leave home to escape continuing school failure; others are forced to leave home when their families refuse to tolerate their dropping out of school (Shaffer and Caton, 1984). In a 1987 survey of 150 shelter programs, the National Network of Runaway and Youth Services found that 59% of sheltered youth reported having school problems (Children's Defense Fund, 1989).

As a prerequisite for learning, youth first must find some refuge from the fear and anxiety that shadow them on the street. Also, many homeless youth need to be convinced that they have the ability to learn and that school is not necessarily a punitive, hostile place. Staff at many of the programs that we visited, however, contend that the school system is failing youth who already have dropped out, as well as those at risk of dropping out. As one director told us (and his sentiments were echoed many times over): "Our schools are not meeting the needs of high-risk kids. They are not teaching critical thinking and survival skills. They are turning a blind eye to gang involvement and substance abuse. The attitude is 'Get these bad kids out; they are not my problem.'"

To create a nurturing learning environment for youth who may be many grade levels behind in basic skills and need an opportunity to catch up without feeling embarrassed, most of the programs we visited (sometimes in collaboration with school districts) have created alternative classrooms or special schools for homeless youth. Along with a willingness to accommodate the anxiety, depression, low self-esteem, hunger and physical exhaustion that homeless youth bring to school, these alternative education components utilize diagnostic and prescriptive teaching methods that enable teachers to design an individualized lesson plan for each student. Students proceed—and succeed—at their own pace.

Program staff, as well as researchers, emphasize that education programs, to be effective with runaway and homeless youth, also must incorporate basic reading and math skills acquisition and self-esteem building (Boyer, 1988). Schools that provide an independent living course, an alternative curriculum for homeless youth, and counselors who can link youth to community resources are also an essential source of survival skills training. For example, alternative education programs usually provide accurate AIDS prevention information. For homeless youth who are living on the street or with friends, this education component may be their *only* link to such life-saving information.

Staff indicated the following advantages of alternative education components:

- Survival skills classes can provide accurate information about AIDS, drug abuse, physical abuse and legal rights, as well as realistic information about independent living and employment and training opportunities.
- Counselors can link youth with community agencies and church groups that provide mental health services, health care, food, clothing and job training.
- Basic skills training teaches youth to read, which is the ultimate survival skill. (Those street youth who are not "functionally literate"—indicating they cannot read at the sixth-grade level—are ineligible for most jobs.)

Recently, to meet the requirements of the Stewart B. McKinney Homeless Assistance Act of 1987, the State of California collected data from 366 school districts, 58 county offices of education and 72 shelters on the educational needs of homeless youth. Respondents were asked

to list strategies for keeping homeless children and youth in school. The recommendations that were particularly applicable to high school age youth included these:

- Establish a central, computerized clearinghouse for school records;
- Provide youth with clean clothes, food and school supplies;
- Provide tutors for after-school instructional support and a quiet place to do homework at shelters and at transitional living houses;
- Sensitize teachers and counselors to the problems of homeless youth by inviting them to spend time at shelters;
- Establish better coordination between community service agencies and the schools and between shelters and the schools;
- Station an ombudsman or case manager at the school who has access to other social services;
- Provide immunizations and physical examinations on-site through a school-based clinic or a health van that makes regular visits to the school;
- Provide on-site child care and parent education for teenage mothers; and,
- Ensure effective outreach to homeless youth.

(California State Department of Education, 1989)

Many of these recommendations come with a relatively high price tag. In jurisdictions where special school programs for homeless youth have been established, the higher teacher-to-pupil ratio, the special curricula, additional counselors and added classrooms necessary all increase the per-pupil cost. For example, the state pays San Diego's public schools $3,800 a year per pupil. However, the state pays the county nearly $5,000 per year for youth enrolled in the alternative education component. Staff at several programs expressed concern about the future of alternative education components in the face of anticipated federal, state and local cutbacks in education spending.

Besides funding, another stumbling block to providing an enriched, holistic school program for homeless youth is the reluctance of categorical youth-serving agencies to engage in the

complex process of interagency collaboration. To provide access to health and mental health care, counseling and other special services within a school setting requires: affiliation agreements between agencies; willingness to out-station staff; innovative strategies for shared funding; and, shared responsibility for oversight and evaluation. In communities where such collaborative programming has not been tried, advocates for homeless youth have the added job of convincing policy makers that no one agency has the resources to assume sole responsibility for multi-problem youth.

Viable Strategies

YouthCare in Seattle was one of several programs we visited that reported a successful collaboration with the local school system. The Seattle Public School's (SPS) collaboration with YouthCare reflects an unusual long-term policy commitment on the part of a local school district to address the educational needs of runaway and homeless youth. The school system was an original partner in the consortium that launched YouthCare's drop-in center.

In the early 1980s, in an effort to reach more at-risk youth, Seattle Public Schools abandoned the traditional single-site concept that requires students to come to one centralized facility for education. Instead, SPS embraced a policy of bringing education to high-risk youth. For example, SPS established off-site classrooms at runaway and homeless youth shelters. As a result of this policy shift, SPS is now serving 200 youth at any given time (and 400 over the course of a year) at 13 alternative *Learning Centers,* in contrast to only 60 high-risk youth who previously attended the single-site school. In addition to off-site classrooms at alternative youth services agencies, such as YouthCare, the Learning Centers include three special education sites and a center at the King County Juvenile Detention Center.

YouthCare is home to two Learning Centers—one located at Orion Center (its drop-in program), and one located at its headquarters, which serves youth living at YouthCare's runaway shelter and transitional living facilities. The curriculum at YouthCare's Learning Centers, which are open from 10:00 a.m. to 6:00 p.m., emphasize basic skills, survival skills, computer literacy and building self-esteem. Youth can earn required high school diploma credits or credits for the GED.

The curriculum is individualized, and youth have a role in setting their own goals. Seattle Public Schools provides one full-time teacher and one full-time teacher's aide at each center, as well as computers and supplies. YouthCare's education component has a special relationship with Seattle Central College, where at least 10 youth, who have graduated from the Learning Center, are enrolled; they continue to receive support from YouthCare staff and financial aid. SPS also assists youth to go from Learning Centers to regular classrooms.

Learning Center teachers usually have experience in working with high-risk youth, often in the juvenile justice system. While they receive the same salary as regular teachers, they have more freedom and flexibility, more access to training and more time for planning in recognition of the nature of the population they serve. YouthCare teachers, like all other direct service staff we interviewed, report a more seriously disturbed population of youth that is more involved in self-injurious forms of behavior, such as prostitution and substance abuse, more older, homeless youth and more pregnant teens. As a result, teachers report being more stressed and security conscious than in the past. However, Learning Center teachers indicate that it is not the challenging nature of the youth, but economic realities that create the most frustrations and would force them out of teaching. For example, teachers complained about the lack of an urban pay differential in high cost-of-living areas, such as Seattle.

Seattle Public Schools has developed some innovative approaches to keeping teachers invested. For example, in order to improve computer literacy among Learning Center teachers, SPS struck a bargain that allowed teachers to keep and take home the computers and software on which they were trained. There was 100% attendance at training and the added advantage of home and classroom computers now being compatible.

SPS and YouthCare reported that, while Seattle's public school enrollment has been declining over the past decade, the enrollment at Learning Centers has been increasing. SPS and YouthCare statistics, as well as teacher reports, indicate that the Learning Centers are a successful approach to educating runaway and homeless youth. Attendance is high; reading and math test scores have improved; and, behavioral and social skills have improved, as has job readiness.

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Albuquerque's **Youth Development, Inc.** operates two alternative education components: the *Stay-in-School Program* based at two Albuquerque high schools, and the *GED Prep/Entry Employment Program.*

The *Stay-in-School Program* serves about 80 youth each semester, primarily those who are at risk of dropping out, as well as some who have dropped out. The program operates at two sites: Rio Grande High School and Valley High School. It serves primarily Hispanic youth and their families, who are referred from other YDI components, such as the runaway shelter, school personnel and other youth. In addition, Stay-in-School does its own outreach to youth who are failing in regular classrooms.

Stay-in-School employs two full-time teachers, two counselors and one job placement specialist. Teacher : student ratios are no more than 1:12. The program is funded by the Job Training Partnership Act (JTPA) and a small subsidy from county Community Development Block Grant funds to cover those youth who do not meet JTPA income criteria.

Stay-in-School offers small, individualized instruction in English and math, individual and group counseling, parental involvement, family counseling and after-school employment. Stay-in-School links youth to YDI job training and development components, but youth must attend school in order to work.

Stay-in-School makes a concerted effort to involve families in the program. It holds weekly family meetings at a site midway between Rio Grande and Valley High Schools so that families will not feel that one group is being favored over another. It enlists parental input on the issues parents feel are most important, which have included substance abuse (youth and parental), AIDS and teen pregnancy. About 50% of the parents attend. As one counselor told us, "We are probably not reaching the <u>most</u> dysfunctional parents, but we <u>are</u> seeing parents who would not go anywhere else for help." Staff believe that parental involvement is critical for keeping youth involved. Often, youth and parent groups are discussing the same issues. For example, Stay-in-

School runs a weekly Children of Alcoholics group for students and, at the same time, focuses on parental alcohol abuse at its parent meetings.

The message that Stay-in-School tries to convey to both students and parents is a sense that the program is committed to youth and families for the long haul. Indeed, in the four-year history of the program, only three youth have been asked to leave, and then only after many tries to keep them. The program accepts virtually all youth, except for those 17 and over, who are referred to the GED Prep Program, and youth who need a self-contained, special education classroom. In 1989, 100% of youth enrolled in Stay-in-School passed the New Mexico competency exams in math, and 92% passed in English.

The *GED Prep/Entry Employment Program*, started in 1984, is a state accredited alternative education program that serves youth, ages 16 to 21, who have dropped out or been expelled from school. Students attend a structured educational component for three hours a day, either in the morning or afternoon (15 hours a week), and work three hours a day (15 to 20 hours a week). Staff include a teacher and a job developer, who are funded by the Job Training Partnership Act.

GED Prep serves 16 youth at any given time (eight in the morning class; eight in the afternoon), and a total of about 85 youth a year. Students primarily are Hispanic youth who have been involved in the juvenile justice system. To enroll in GED Prep, youth must be "at risk" (defined as juvenile offender, teen parent, homeless or substance abusing); between the ages of 16 years, 11 months, and 21 (younger youth are referred to Stay-in-School); low income; school drop-out; unemployed; and, reading at an 8th grade level or higher. Youth are referred from probation, other YDI components, other youth and other youth services agencies. The program not only incorporates individualized employment training and education, utilizing a computer competency based curriculum, but it links youth to other needed services.

Like Stay-in-School, GED Prep successfully integrates education and employment training. The education curriculum includes instruction in the five basic competency areas of the GED exam, as well as job readiness skills. GED Prep provides jobs for students, usually in community improvement projects, including such YDI components as the Gang Intervention Project.

Participants are paid the minimum wage, but do not get paid unless they attend school. Upon completion of the program, GED Prep's job developer helps youth to obtain permanent employment.

The average stay in the program is 12 to 16 weeks. In 1989, 98% of enrollees completed the program; 98% were placed in permanent jobs, 75% of these in the private sector; 60% passed the GED exam. The program was a 1989 recipient of the Presidential Award for Excellence in serving high-risk youth.

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Bridge in Boston also has an *educational/pre-employment component,* serving youth 16 to 21, that has been in existence for 15 years. The curriculum is individualized, teaching basic competencies, job readiness skills and word processing. Residents of the transitional living programs and participants in the Family Life Center are encouraged to use this component. The program enrolls 160 youth, 50 of whom graduate and find jobs in the course of each year. Each year about 10 go on to college; Bridge staff provide support and help in obtaining financial aid. Bridge holds an annual graduation ceremony to honor those students who pass the GED.

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The Storefront in San Diego (like YouthCare in Seattle) has a special alternative school for its homeless teens that was established by the San Diego County Office of Education to respond to the increase of homeless school age children and youth that occurred during the 1980s. In addition to establishing the *Homeless Outreach School* at The Storefront and one for young children at another shelter, the San Diego school system took two other innovative steps: they created a centralized referral and placement office for transient students, and waived geographic boundary requirements so children and youth residing in shelters could continue to attend their former neighborhood schools.

The Storefront's school is officially considered a juvenile court school, since California's welfare code places all homeless children under court authority; this connection to the juvenile court system enables the school to receive a higher per pupil reimbursement rate from the San Diego County Office of Education.

The Homeless Outreach School was housed initially on the second floor of The Storefront's shelter. When the school outgrew those small quarters, it moved to a nearby warehouse, which affords room for 20 students, a kitchen and closets large enough to hold all the clothing and shoes donated to the school by citizens and local stores.

Almost all of the youth staying at The Storefront shelter go directly to school when the shelter closes at 8:00 in the morning, even non-English speaking teens. Youth who are too tired to work are allowed to sleep, and for those who are hungry, there is breakfast (and lunch later in the day).[15] Since some teens who are still living on the streets also come to The Homeless Outreach School, there are facilities to wash up and change into clean clothes. As staff put it: "If a kid is exhausted and dirty and has no shoes, you can't expect him to learn fractions."

Initially, many youth come to school because the word on the street is that it is a safe place, where subsistence needs and emotional problems are as important as academic deficits. In exchange for the tangible food, clothing and nurturing they receive, students are explicitly told that they are expected to study and to learn. "I did a lot of work to get those clothes, now what are you going to do," is a frequent question that the school's teacher asks teens who come to school ostensibly only for a pair of sneakers or jeans.

Students negotiate a schoolwork contract each week, which they sign and keep in their own folders. Individualized lesson plans and work sheets allow teens to proceed at their own pace without embarrassment. If students drop out for a week or longer, they can easily pick up where they left off by referring to their folders, which are kept at school. Traditional "stand-up" teaching is impossible at the Homeless Outreach School, not only because academic skills vary widely, but

[15]Day-old food left over from banquets is donated by Love's Gift; Pizza Hut also makes regular contributions.

because the students, most of whom have experienced emotional neglect, crave and compete for the teacher's attention, much like very young children.

Although the Homeless Outreach School and The Storefront share most of the same caseload and depend on each other's services, they continually struggle to work out a satisfactory collaborative arrangement. One shared source of pride for both programs is the high degree of commitment and participation in the school program on the part of homeless youth. Three-fourths of the students who attend the school graduate with a California High School Proficiency diploma; a few have completed the additional course work required for a GED; and, nine Outreach students are currently enrolled in college. The Outreach School's teacher—somewhat of a local celebrity—uses her lecture fees from speaking engagements to pay the first year's college tuition for all Outreach School students.

In 1991, The Outreach School will expand again, not only to larger quarters that can accommodate 50 students, but also to incorporate on-site social services, including employment training, mental health and training in daily living services. The regular school day will be extended to 5:00 o'clock.

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The Iowa Homeless Youth Center does not have an on-site alternative school program, but utilizes Des Moines' two alternative high schools, a near-by comprehensive high school, which has on-site case management and social services, as well as the Des Moines community college which offers a GED program.

North and South Alternative High Schools differ from Des Moines' regular high schools in several ways: the school day ends at noon (enabling teens from IHYC to hold afternoon jobs); and, students are not expelled after 13 unexcused absences as are regular public school students. Students at the alternative high school are expected to demonstrate proficiency in basic subject areas, but are not required to attend school regularly or to complete a course of study within one school year. This flexibility is encouraging to homeless youth, who otherwise fear having to start

all over again because they have missed many weeks or months of school. A course in independent living skills is required for graduation. Classes are small and relatively informal, and praise and nurturing are handed out in liberal doses.

A major source of praise and nurturing is the school social worker who, despite her large caseload, stays in touch with the more troubled students, including those from the Iowa Homeless Youth Center, whose attendance she monitors closely. In her role as resident case manager, the school's social worker connects her students with a wide array of community resources. She plays an especially significant role in assisting the large number of students—25% in 1989—who are living independently.

EMPLOYMENT AND TRAINING

Issues

At a majority of the programs we visited, youth workers cited an urgent need for in-house employment and training components specifically tailored to runaway and homeless youth. Although there are some notable exceptions (discussed under Viable Strategies below), most of the programs provide only limited on-site job counseling and job development services, not comprehensive, structured employment and training programs. Some programs have arrangements to access employment and training services from other agencies in the community who specialize in this area; however, most expressed a preference for developing stronger in-house components.

The ingredients of successful employment and training programs for high-risk youth have been well documented (Taggart, 1981; Act Together, Inc., 1983; DeLone, 1990) and are well known to the runaway and homeless youth program staff we interviewed. They include:

- An individualized, graduated approach;
- The teaching of basic education, social and life skills, in addition to "world of work" preparation (some research also cites the importance of teaching specific vocational skills);
- Use of competency-based, computer assisted basic skills curricula, which allow youth to proceed at their own pace while providing ongoing feedback;

- A year-round program to prevent summer learning loss and to provide the time necessary to work intensively with high-risk youth;
- A comprehensive focus that takes into account the multiple problems of high-risk youth and coordinates services with other agencies, particularly education and social services;
- Use of job developers and job counselors to assist both employers and youth;
- Competent, dedicated staff; and,
- Stable funding.

Many studies indicate that traditional employment and training programs are neither reaching most runaway and homeless youth (nor most disadvantaged youth generally), nor meeting the needs of those whom they do reach. Robertson (1990), for example, found that homeless youth have little access to regular employment and training programs. Public/Private Ventures (P/PV) notes that less than 5% of eligible youth are served by the Job Training Partnership Act (JTPA), the major federal employment and training program. Few of the youth JTPA does serve are the highest risk: less than 30% of youth served by JTPA are school drop-outs (whereas close to 75% of runaway and homeless youth are drop-outs); less than 10% are single parents (an estimated 30% of homeless youth are pregnant or single parents); and, less than 5% have limited or no English-speaking ability (whereas immigrant youth make up a growing proportion of the client population in a number of the programs we visited, such as The Storefront, where an increasing number of youth served have limited English-speaking skills) (Public/Private Ventures, 1990).

There are many reasons for the failure of traditional employment and training programs to reach high-risk youth; they are cited in the literature, as well as by staff at the programs we visited. As noted throughout this report, high-risk youth, and runaway and homeless youth in particular, have an array of problems that require comprehensive, coordinated types of interventions. Yet, as the P/PV study notes:

> ... youth employment programs have been either unwilling or unable to meet the multiple needs of at-risk youth ... everything we have learned to date about how to affect the life chances of these youth indicates the need for longer-term and/or more intensive interventions that draw on a variety of resources and services.
>
> (Public/Private Ventures, 1990)

Indeed, one of the major findings of P/PV's recent survey of practitioners in local employment and training programs echoes findings in this report—namely, that youth today are at significantly higher risk, with a greater array of problems demanding more comprehensive, integrated interventions. The Advisory Committee to the JTPA program recently issued a report in which it, too, stressed the need for JTPA to build linkages with other systems to improve outcomes for high-risk youth (Public/Private Ventures, 1990). P/PV found that most of the JTPA-funded employment and training programs it surveyed were receiving no federal or state health and human services, housing or juvenile justice monies to augment their job training services. In a similar vein, most of the runaway and homeless youth programs in our monograph received no JTPA funds, while virtually all drew on health and human services, housing and juvenile justice funding sources.

The programs we visited were especially critical of JTPA, whose guidelines, they contend, limit the number of youth that can be served and impose job placement standards that are unrealistic for programs working with high-risk youth. Staff complained that JTPA places unrealistic limits on the amount that can be spent on support services and on the time that youth can be enrolled in training. These complaints echoed charges that have been made nationally about JTPA. Specifically, it is contended that JTPA's eligibility criteria, placement standards and categorical focus encourage "creaming"—i.e., enrollment of easier to serve youth. Youth workers also were highly critical of JTPA's reporting requirements, which they viewed as unnecessarily burdensome. As one job trainer told us: "We end up filling out 50 pieces of paper for each youth; the time could be much better spent working with the youth or an employer."

Neither researchers nor the programs we visited underestimate the difficulty of providing effective employment and training services to runaway and homeless youth. The suspicion with which street youth view services, their access to illegal sources of income, primarily through prostitution and drugs, as well as their multiple problems, pose formidable barriers. P/PV, for example, notes that among the hardest youth to reach are those involved in underground economies of drugs and prostitution and those who, in addition, are homeless and have physical health, mental health and substance abuse problems, a description which characterizes many street youth (Public/Private Ventures, 1990).

As noted earlier, most of the programs we visited, although they understand fully the need to create alternatives to street income, do not have well-developed employment components. Funding constraints, the barriers posed by traditional employment and training programs, especially JTPA, and lack of staff expertise partially account for this absence of in-house capacity. However, we were also told that, during the early to mid-1980s, the plentiful supply of low-skilled jobs acted as another disincentive. In effect, low unemployment and job availability made it easier for youth to find jobs without training. As we move into the 1990s, the employment environment is drastically changing. Many of the sites already are experiencing widespread unemployment, and there is a growing discrepancy between the skills employers need and the skills youth have to offer. Youth are increasingly discontented with fast food and other unskilled jobs which they feel carry a stigma. Yet another employment problem is posed by a lack of decent jobs for youth under 16, at a time when the number of young teens involved in street life is increasing.

Viable Strategies

Youth Development, Inc. in Albuquerque has a comprehensive employment and training component, which recognizes the relationship of basic academic skills to successful work experience and training. The integration of education and employment and training is an essential aspect of YDI's program.

There are four main components of YDI's overall employment and training program: the *Stay-In-School Program,* targeted to youth under 17 who are at risk of dropping out of school; the *GED Prep/Entry Employment Program,* targeted to school drop-outs, ages 16 to 21; the *Summer Youth Employment Program*; and *YES,* YDI's Youth Enterprise Operations, which involves youth of all ages but especially targets job opportunities for youth under 16, who may have fewer job options in the community.

As discussed also in the education section of this chapter, the Stay-In-School Program operates out of two Albuquerque high schools. The program combines: small, individualized instruction in English, math and life skills; individual and group counseling; after-school employment; job placement, job counseling and preparation for the world of work through

interviewing techniques, role playing and career counseling; participation in an annual leadership institute; and, after school, entry level job placements.

Stay-In-School staff include two full-time teachers, two counselors and one job placement specialist. The program's budget is covered mainly by JTPA, but YDI also draws on Community Development Block Grant funds to cover youth who do not meet JTPA eligibility criteria. Albuquerque Public Schools provide in-kind support, including classroom space, supplies, telephones and copiers.

The GED Prep/Entry Employment Program, a state accredited alternative education program, started in 1984, serves youth ages 16 to 21, who have dropped out or been expelled from school. Students attend a structured educational component three hours a day, either in the morning or afternoon (15 hours a week), and work three hours a day (15 to 20 hours a week). Students do not get paid unless they attend school.

Like Stay-in-School, GED Prep successfully integrates education and employment training. The education curriculum includes instruction in the five basic competency areas of the GED exam, as well as job readiness skills. GED Prep provides jobs for students, usually in community improvement projects (including such YDI components as the Gang Intervention Project). Participants are paid the minimum wage. Upon completion, GED Prep's job developer helps each youth to obtain permanent employment. The program serves about 85 youth a year, who receive training for 12 to 16 weeks. In 1989, 98% of enrollees completed the program; 98% were placed in permanent jobs, 75% of these in the private sector; 60% passed the GED exam. The program was a recent recipient of the Presidential Award for Excellence in serving high-risk youth (see the education section of this Chapter for more detail).

Since 1978, YDI has contracted with the Private Industry Council to provide a comprehensive Summer Youth Employment Program (SYEP). The program, which serves low income, disadvantaged JTPA-eligible youth, ages 14 to 21, usually has a waiting list. YDI staff use a point system to identify the most at-risk youth, who are moved to the top of the waiting list.

By the starting date in 1990, YDI had identified and certified 1,500 youth, but it had funds to serve only 870.

SYEP youth work 30 hours a week for eight weeks and are paid the minimum wage. They are placed with government and nonprofit agencies and in community improvement projects, many of which are run by YDI. Community improvement projects, or "community pride", as YDI calls them, have included a major landscaping of 13 median strips in a poor area of Albuquerque; construction of a solar greenhouse at a rehabilitation center for the handicapped; construction of exercise stations located alongside jogging trails; and, graffiti elimination in the barrios where many of the youth live. YDI has had long-standing relationships with many of the agencies at which youth are placed, including Kirkland Air Force Base and the University of New Mexico. Unlike many summer youth employment jobs, YDI staff make sure job placements are productive for both employers and youth by conducting pre-placement site visits to every potential site and weekly visits once youth are placed. This hands-on approach to developing and nurturing job placements is a key to the success of YDI's program.

SYEP is funded through the Private Industry Council, principally using JTPA dollars as well as city and county employment and training monies. In 1990, a significant cut in JTPA funding resulted in YDI's having to reduce the number of participants from the previous year by more than 20%.

YES (an acronym for Youth Employment System) encompasses YDI's youth enterprise business operations, which include a painting company, a thrift store and a silk screening business. On the drawing boards for the 1990s are a restaurant and an office management business. YES serves youth of all ages but, in particular, provides work experience to younger adolescents (under 16) who have more difficulty finding jobs in the community.

YES's thrift store, which opened in 1985, employs four youth at a time, who work up to 100 hours at minimum wage, learning bookkeeping, marketing, display, salesmanship, management, and appliance repair and maintenance skills. Because the thrift store is not yet self-sustaining,

wages youth receive are subsidized by Community Development Block Grant funds, and overhead is supported by YDI general operating monies.

The painting company, which started in 1983, is licensed by the State Construction Industry Bureau and is self-supporting. Recently, the company won a competitive contract from Albuquerque Public Schools to paint in various city schools.

YDI views its youth enterprise operations as apprenticeship training programs and is trying to develop stronger relations with unions both to improve the quality of training and increase the number of permanent job placements. YDI also is trying to develop stronger ties to the small business community in Albuquerque to avoid potential complaints of "unfair competition" if its tax-exempt, nonprofit enterprises compete with for-profit businesses providing the same service or product.

Eventually, of course, YDI would like all of its Youth Enterprises to operate as profitable business ventures. When advising others, YDI stresses the need to start with businesses, such as the painting company, that require little capital investment.

YDI's employment components—Stay-In-School, GED Prep/Entry Employment, SYEP and YES—operate collaboratively with one another, as well as with other YDI components. Thus, an 18-year-old homeless adolescent may be living at YDI's transitional living house, be enrolled in GED Prep/Entry Employment and working at the thrift store. A younger runaway may be at YDI's emergency shelter and enrolled in Stay-In-School. This comprehensive, coordinated approach, as opposed to one single, time limited component focusing principally on employment training, gives YDI a great deal of flexibility to address the multiple needs of high-risk youth.

CHAPTER V.

ORGANIZATIONAL ISSUES AND STRATEGIES

Despite their differences in size, location and structure, the programs we visited grapple with similar organizational issues. Problems related to policies and procedures, boards of directors, staff recruitment and retention, use of volunteers, collection of data, program evaluation, research and the extent to which families and youth are involved in program governance and operations provide as significant a challenge as the youth themselves. Effective programs manage to create an organizational "context" that balances two often competing demands. On the one hand, programs need to be accessible and responsive to teens and, thus, flexible and informal in service delivery. At the same time, they need to be accountable to funders and cognizant of sound management principles, and, thus, efficient, cost-effective, quantifiable and structured. This chapter discusses organizational issues and strategies that create balance and contribute to a healthy context for service delivery for runaway and homeless youth.

POLICIES AND VALUES

The world of alternative youth services agencies is inherently unstable. Funding is precarious (see Chapter VI). The youth population poses constantly changing demands. Economic and political realities shift quickly, tempting programs to develop new service components as funding becomes available or as new sub-populations of youth emerge. Successful programs are able to be flexible enough to respond to youth needs and to take advantage of new funding opportunities without violating fundamental program integrity. Their success at this can be attributed to several factors:

- Careful thought has been given to develop mission and values statements and clearly articulate them to the board, staff, volunteers, youth and the community. The discussion of guiding principles in the Introduction is representative of the values that guide the programs we visited.

- Time has been devoted to develop clear, written policies and procedures that operationalize the mission and program values. As one administrator told us, the policies and procedures manual "is essential to our survival; without those guidelines to steady us, we'd capsize."

- Effective programs orient new staff to program policies and procedures and regularly review them through in-service training, case conferences, policy meetings and annual retreats.

- The process for developing and revising policies and procedures, which involves board members, staff, and often youth, family and community representatives, is as important as the product. Effective programs make sure their policy manuals are reviewed periodically to keep them relevant and dynamic.

In addition to articulating mission and values, the policies and procedures manual serves the important function of translating lofty ideals into examples related to daily practice. Manuals that specify practices which violate agency policy, as well as those that implement it, are especially useful to staff, as are explicit job descriptions and a clear delineation of supervisory relationships (see Appendix H for excerpts from Policies and Procedures Manuals).

When board, staff and volunteers are clear about the program's mission, there is far less tendency to "chase dollars", develop new services or take on new sub-populations of youth inappropriately or precipitously. There are, instead, guidelines and a process in place for making informed decisions before assuming new challenges. There is also less anxiety on the part of staff which, in turn, makes for better service delivery, since staff uncertainty invariably conveys itself to youth. Having the values and policies in place makes it easier to resolve problems when they occur. **The Storefront** provides one example.

State auditors found that young adults (youth over age 18) were being admitted to The Storefront in violation of program policy, which reserved The Storefront for 13- to 18-year-olds. With assistance from two consultants, San Diego Youth and Community Services (SDYCS) conducted a thorough evaluation of The Storefront's personnel and policy structure, its service delivery and therapeutic milieu. Rather than making scapegoats of line-staff, SDYCS administrators shared responsibility for the policy violations.

As a result of the consultants' recommendations (which were based on interviews with funders, the Board of Directors, youth and staff), lines of authority were restructured, job descriptions and policies were revised and supervision, case conferences and in-service training were increased. A one-year follow-up evaluation was conducted to ensure that the agreed-upon goals had been achieved. The Storefront emerged from what the staff call its "time of troubles" with the renewed confidence of the community and its own staff, both of which collaborated in bringing about the needed changes.

BOARDS OF DIRECTORS

The dilemma created by expanding population and service needs and shrinking funds has placed new demands on boards of directors who are asked to shoulder ever-increasing fiscal and management responsibilities.

When they first began operations, virtually all of the programs we visited received guidance and oversight from boards composed almost entirely of service providers and youth advocates. Programs that were established in the 1960s and early 1970s sought board members who had been "in the trenches", who understood the frustrations of youth and who championed their values. These founding boards were principally concerned with the character, content and integrity of services.

Today, as programs struggle to find new sources of revenue and to meet the complex housing, health, employment, mental health and legal needs of clients, they seek members who bring, not only commitment to young people, but technical expertise in new areas, such as housing finance, and broader based community connections, who can act as adjunct to staff, take a more active role in fundraising, and provide valuable pro bono technical services. At the same time, programs do not want to lose the strong policy and program expertise that they have had on their boards from the outset; nor do they want their boards to become so large that they are unwieldy. The need to include many different kinds of expertise on today's boards, yet keep board size manageable, has led to some creative board structuring and re-structuring. Changes in board

structure also are being stimulated by the increasing array of collaborative service arrangements among programs, which may require input and guidance from more than one agency's board.

The Iowa Homeless Youth Center in Des Moines is one satellite program in a complex of 15 programs located in six counties throughout Iowa; this far-flung endeavor is managed by a central administrative agency, Youth Shelter and Services (YSS), based in Ames.

When the Iowa Homeless Youth Center opened its doors in 1986, a Community Advisory Board, composed mainly of local celebrities (including the wife of the Governor, who still serves as Honorary Board Chair), oversaw its activities. Although the local Advisory Board was given responsibility for shaping the program's mission, the YSS Board of Directors (the parent administrative body), which meets monthly in Ames, retained the authority to oversee the program, the staff and the budget. Since 1986, a number of factors have led to changes both in the composition of the local Advisory Board's membership and the scope of its involvement in the IHYC:

- Originally dedicated to finding missing youth, IHYC changed its focus in 1986 and began securing shelter and support services for street youth; and,

- In 1990, IHYC, which had been housing youth at the YWCA and in somewhat decrepit motels, purchased and remodeled a house in a residential neighborhood of Des Moines and opened a seven-bed transitional living center and a mobile outreach unit, thus moving into new program areas.

With these changes, the Advisory Board significantly altered its membership and its methods of operating. Although many of the original "celebrity members", such as the Chief of Police and the Governor's wife, still sit on the Board, the Board's ranks have been augmented with lawyers, business leaders and community activists who have undertaken responsibility for major fundraising for IHYC, and who play an active role to ensure that the funds they raise are well spent.

Perhaps the biggest change in the scope of Board activity is the very fact that it is far more active. The Advisory Board now meets bi-monthly, rather than quarterly. To oversee its increased

responsibilities, the Board has elected a strong Chair, who has organized an efficient system of officers (including a treasurer) and working committees.

As a result of its commitment and expertise, the local Advisory Board has assumed responsibility for tasks and decisions that were formerly the prerogative of the YSS parent Board of Directors in Ames. Although the Advisory Board's new activism causes friction from time to time, the fact that it is comprised of 25 highly respected leaders in the Des Moines community, who raised $300,000 in 1990, has quieted dissension.

Collaboration between the local Advisory Board and the central Board of Directors is fostered by appointing one local Advisory Board member to sit on the parent Board of Directors. This dual membership provides the YSS Board with access to timely information on development in the Des Moines program. IHYC's Program Coordinator, however, must answer to two Boards, a process that is cumbersome and time-consuming.

The Storefront is another example of a smaller program in a much larger network, which is operated by **San Diego Youth and Community Services** (SDYCS). SDYCS has a central Board of Directors that oversees nine separate programs, a staff of 150 and 500 volunteers. Most of the programs under the SDYCS umbrella, including The Storefront, have their own Advisory Boards composed of clients, community members and professionals who provide guidance to program staff. Important policy decisions, however, rest with the SDYCS Board of Directors and the Executive Team, which is made up of SDYCS's Executive Director, the Associate Director and Program Managers.

The 27-member SDYCS Board uses a five-year strategic planning process to guide the agency through a participatory planning procedure involving all staff and Board members. SDYCS contracts with an outside consultant, the Institute of Cultural Affairs West (based in Phoenix, Arizona), to lead them in an all-day planning workshop.

The SDYCS Board re-evaluates program goals annually; any new initiatives must facilitate the five-year plan. However, the Board, which meets monthly, can opt to approve projects that

fall outside the proscribed plan if a unique opportunity should arise that is consistent with the SDYCS mission. This "opportunity management policy" has enabled SDYCS to seize unanticipated options in response to emerging community needs and to remain flexible while still adhering to a long-range plan.

In an effort to use Board members' time more efficiently, SDYCS has established a separate fundraising committee of the Board, whose members are called Trustees. Although they retain full Board membership and voting rights, Trustees (who each make an initial contribution of $3,000) do not attend monthly meetings. Their sole responsibility is to raise sufficient revenue to balance the $4.9 million budget.

Youth Development, Inc. (YDI) in Albuquerque, like many of its counterparts, began operations in the early 1970s as an outreach program with a small budget and a services-oriented Board. Today, YDI is a $2.3 million multi-site operation that is involved in such technically complex areas as housing finance and youth-run businesses. YDI is in the process of re-structuring its Board of Directors to keep pace with its expanded fiscal and management responsibilities.

YDI's new Board structure will encompass a parent body responsible for overall policy direction, which includes individuals grounded in youth services (much like its original Board membership), and two Board subsidiaries—a fundraising subsidiary and an economic development subsidiary—to assist with both housing and business (youth enterprise) operations. Subsidiary members will have the necessary technical expertise and ties to relevant sectors in the community.

This new structure will enable YDI to bring specialized skills to the issues that are unique to certain program components. For example, liability insurance is a major concern in the economic development area; financing poses special problems in the housing area. At the same time, the structure, with its services-oriented parent body, helps to ensure that these specialized areas, and fundraising in general, remain grounded in the basic mission of the agency.

STAFF RECRUITMENT, TRAINING AND RETENTION

A majority of the programs we visited are seeking solutions to similar personnel issues, including the need to:

- Recruit minority staff and provide training in cultural diversity;
- Retain staff despite difficult working conditions and characteristically low pay;
- Determine equitable standards for evaluating performance;
- Provide in-service training;
- Prevent burn-out, especially among those staff who work with short-stay clients and, therefore, do not necessarily see improvements;
- Train (or recruit) staff in "specialty" areas, such as sexual abuse; and,
- Secure funding for training (which is not underwritten by most grantors).

The challenge for alternative youth programs is to keep staff members content so they can withstand the stress of their jobs. Retention of good staff is critical to program stability and effective service delivery. A number of the programs we visited have managed to hold on to staff, literally, for years. At **Bridge,** for example, over one-third of the staff has been at the program eight or more years. Agencies that have avoided high rates of staff turnover attribute their success to a variety of creative policies designed to increase both staff competence and the non-monetary rewards of their work.

At **United Action for Youth**, staff are discouraged from working more than 36 hours per week; in addition, they are expected to account for four hours of "wellness" time on their weekly logs (to make up the requisite 40-hour week). Wellness time is that spent taking care of oneself (by going out to lunch, reading, exercising, etc.). Staff who are unable to find time for such activities—without working overtime—are counseled to prevent burn-out. Similarly, **Bridge** encourages staff to work no more than regular 40-hour weeks, and **YDI** is flexible in giving staff time off.

Former volunteers and student interns frequently graduate to paid positions at **San Diego Youth and Community Services.** Not only does SDYCS profit from the prior in-house training these staff bring with them, they also have proven their worth on the job.

To increase staff confidence, as well as competence, in coping with the changing youth population, each of the programs we visited has instituted in-service training, in spite of the lack of funds for training. In-service training curricula especially targets: the treatment of sexual abuse, family therapy and AIDS. **SDYCS,** for example, requires staff to attend as many as 100 hours of training annually. In addition, many programs, such as the **Iowa Homeless Youth Center, Bridge, YDI** and **YouthCare** give time off for and underwrite the cost of conferences or workshops, and, often, certification and licensing in new competencies, such as substance abuse counseling. Partial payment of graduate school tuition (along with a part-time or flexible schedule) is another strategy that several agencies have adopted. Many programs also use their own staff as trainers, which adds to staff's sense of efficacy, as well as being cost-effective.

Realizing that short-term crisis intervention can be deeply discouraging to staff who rarely see the results of their efforts, some agencies encourage participation in other projects or community efforts on behalf of at-risk youth. At **SDYCS**, for example, staff who take part in interagency collaboration, training or advocacy efforts receive commendation (and extra points) on their annual Job Performance Review; the total number of points received on the rating scale is the basis for awarding merit raises and promotions.

Finally, in effective programs, as discussed in Chapter IV, management supports staff, and staff support one another, through regular meetings, information sharing, the nurturing of a family environment and the encouragement of creativity.

MANAGEMENT INFORMATION, RESEARCH AND EVALUATION

Successful agencies—those that are able to meet their commitments to youth as well as to contractors—have developed information systems which make it relatively easy for administrative and program staff to: record client data; keep an accurate record of services rendered; log dispositions; track funds; and, compile outcome statistics.

The efficient and effective collection and use of information also assists programs to conduct research and evaluation. This capacity has become more important in recent years as funders have begun to insist on sound evaluation components and as programs struggle to develop more viable interventions for increasingly troubled youth. Ironically, funders do not tend to underwrite evaluation, expecting programs to build it into operations; however, many alternative agencies lack in-house expertise in research and evaluation. Effective agencies look to partnerships with universities and others to shore up their evaluation capacity.

Bridge, for example, uses a volunteer researcher from the University of Massachusetts to conduct yearly in-house evaluations of its program components, looking at youth and program outcomes. Bridge's management information system, which includes computerized intake and data collection from all service components, is critical to the evaluation process.

For over five years, research and evaluation have been a priority for **YouthCare's** Board of Directors, which has its own research committee. The YouthCare Board believes research is critical to help the agency become less reactive and assist in long-range planning; it views the purpose of research as one of enhancing services.

YouthCare is in the process of trying to develop an in-house research component, including a director of research, and has begun major fundraising for research and evaluation. The agency has consistently drawn upon the resources of the University of Washington and other academic researchers, and will continue to do so; however, its interest in having greater control over research, as well as the extent of its current research and evaluation activities, is moving it in the direction of stronger in-house capacity as well.

Currently, YouthCare has three research and evaluation projects: a project funded by the federal Office for Substance Abuse Prevention, as part of the Gang Intervention Project, that involves pre- and post-testing of youth to measure outcomes; a project funded by Centers for Disease Control to measure high risk behavior and AIDS awareness among street youth; and, a project funded by the National Institute of Mental Health to test an intensive case management model with street youth. All of these projects are carried out in collaboration with university researchers and state and local agencies.

YouthCare makes a point of involving both line staff and youth in research design and feedback. It uses tests as a means of developing rapport with youth. The program currently is asking all youth it serves to become involved in research activities, primarily by agreeing to pre-service and post-service testing, in an effort to develop a more comprehensive data base on homeless youth. YouthCare's interest in doing more research in this area stems from the 1983 "Street Exit" project it undertook, funded by the U.S. Department of Health and Human Services, involving an ethnographic study of street youth. The results of that research had significant implications for service delivery, such as the need for youth to be more involved in their own care and the need for longer term housing options. To support research and evaluation efforts, YouthCare systematically collects descriptive data across its program components (just as Bridge collects statistical data).

In 1989, **United Action for Youth** (UAY) converted all client records to a computerized data management system. Using the Q and A Software package, UAY developed a format for recording client intake information and a daily service log; these provide the raw data needed to track individual clients, to monitor various programs within UAY, to compute program and client costs, to compile client characteristics and to determine outcome data (see sample data collection forms in Appendix I).

The midwest regional consortium of federally funded runaway and homeless youth programs, called M.I.N.K. (an acronym for Missouri, Iowa, Nebraska and Kansas), contracted with UAY for assistance in establishing a common data base, using "Q and A" software; the recently installed computer hook-up facilitates collaboration and an easy exchange of information among

programs in these states through its Computer Bulletin Board, which provides announcements of training opportunities, funding and grant opportunities, successful program initiatives and job openings. The Bulletin Board interfaces with an extensive list of human service programs in Region VII, including Headstart programs.

VOLUNTEERS

Despite their limited resources, successful agencies expend time, energy and scarce dollars to recruit, train and retain volunteers. Both program staff and administrators assert that their investment reaps lucrative rewards, including:

- Additional people and time to nurture, listen to and counsel teens;
- An opportunity to build an advocacy base in the community;
- Potential donors, Board members and staff members;
- Valuable pro bono skills and in-kind resources; and,
- Increased racial diversity.

Programs employ different strategies to recruit, train, screen and manage volunteers, including the use of full or part-time volunteer coordinators on staff and pooling recruitment efforts with other agencies in the community.

In San Diego, **SDYCS** organized a consortium of five local programs to set up an interagency volunteer recruitment and referral service. Initially, the Volunteer Project, as it is called, was funded by a start-up grant from the state; now its $50,000 annual budget is subsidized through private donations. Volunteer Project staff perform an initial screening, then refer volunteers to the member agencies.

Because SDYCS recruits over 500 volunteers from the Volunteer Project each year to work in all SDYCS components, many individual SDYCS components, such as The Storefront, also have their own volunteer coordinators. The Storefront's Volunteer Coordinator holds weekly

orientations for potential volunteers during which the program is described with "brutal honesty"; volunteers are reminded that they are expected to make a commitment to work at least five hours per week for a minimum of six months. Recruits undergo individual interviews and complete a written application that includes a request for professional references (each of which is checked), finger prints, a TB test, and a check to determine the existence of a criminal, child abuse or reckless driving record.

Once volunteers for The Storefront have completed this second screening (the first having been with the Volunteer Project), a three-hour orientation acquaints them with the values and regulations of the program "milieu". Volunteers sign a contract to confirm their acceptance of agency policies, especially the policy that forbids any outside contact or "special relationship" between volunteers and youth. For the first two months, new volunteers are on probation, after which they are given in-depth evaluations every six months. In addition, volunteers must attend monthly in-service training, many of which bring together volunteers from the five other agencies participating in the Volunteer Project.

An important aspect of the Volunteer Coordinator's job involves training staff to work successfully with volunteers. She must ensure that volunteers are valued and respected, and that they receive adequate supervision and recognition. Often called upon to mediate a misunderstanding between a staff member and a volunteer, the Coordinator considers "convincing staff that volunteers are worth the effort" crucial to the success of a volunteer program.

Neon Street in Chicago also employs a full-time volunteer coordinator and requires thorough screening and training of its volunteers. Neon Street uses professionals as volunteers, including physicians, lawyers, business executives, etc. There are about 40 involved in the program at any one time.

Like The Storefront, Neon Street has an intentionally rigorous screening process for volunteers. Not only does the process help to ensure quality, but it also discourages those who are not sufficiently motivated. Prospective volunteers must submit four letters of reference and go through two in-depth interviews. They must complete a 20-page questionnaire, undergo a

security check, and agree to adhere to the agency's code of conduct. They have a six-hour orientation and monthly in-service training in such areas as intake, crisis intervention and group dynamics. Volunteers must commit to six hours a week of service for one year (after one year, volunteers may negotiate fewer hours). Volunteers are evaluated after their first 72 hours and then annually.

As part of her recruitment strategy, the Volunteer Coordinator targets different groups of professionals each month, for example, the medical community one month, lawyers' groups the next. Neon Street also has strong relationships with area universities for using student interns, and it also uses Vista volunteers. Volunteers are covered under the agency's liability policy.

Neon Street holds an orientation for new volunteers every six weeks. It accepts only one out of every five potential volunteers and one out of every 12 student intern applicants. Neon Street has found that it is more difficult to retain volunteers than recruit them (although recruiting volunteers willing to do administrative work, as opposed to direct service, is a perennial problem). To help with retention, Neon Street created a volunteer advocate position and will be starting to conduct formal exit interviews to determine why volunteers leave. Volunteers stay, on average, six to nine months.

Neon Street uses volunteers for the following kinds of activities: tutoring; finding job placements; conducting intake; mentoring; and, facilitating groups such as weekly men's and women's groups. Volunteers also provide legal services; health education; maintenance (painting, repairs, etc.); and, administrative support.

While **Bridge** in Boston does not have a volunteer coordinator, it has been successful in recruiting over 200 volunteers from the medical and dental professions to staff its mobile medical van and dental clinic, as well as volunteers for its residential programs. Each component manager's job description includes the coordination of volunteers as an important function. Bridge provides ongoing training for its volunteers and promotes communication through a regular newsletter for medical and dental volunteers.

A half-time Volunteer Coordinator recently hired at the **Iowa Homeless Center** recruited and trained 15 volunteers who assist staff on the outreach van, serve as mentors, sort clothing and furniture donations and assist the house parents and the residents with daily chores.

YOUTH AND FAMILY INVOLVEMENT

Although most of the programs we visited are committed to involving youth and families in agency governance and program operations, few have been very successful. Several program administrators at the sites we visited expressed regret that family members seem unwilling to play a significant role in program governance. However, other administrators admitted that their attempts at outreach to parents have not been nearly as energetic or creative as their outreach efforts to youth.

At some sites, the lack of family involvement at the administrative level is a reflection of the absence of family preservation and reunification efforts at the program level. Although some program administrators expressed a wish to strengthen their family preservation components, they contend that their efforts are stymied by several factions: a lack of trained staff or available funds to hire such staff; a lack of community-based family preservation services to which alternative programs have access; and, the failure of local child welfare agencies to collaborate with runaway and homeless youth programs in providing family preservation services to troubled teens.

Several programs have made a concerted effort to involve youth in program governance by appointing youth members to the boards of directors. Generally, this tactic has not been successful. Board members are reluctant to discuss sensitive staff issues in front of youth members; and, youth members often feel like token representatives.

Youth-run service components have met with greater success as a means of empowering teens. **United Action for Youth**, for example, recently initiated a telephone warm line that uses teens as phone counselors two nights a week and all day Saturday to handle non-crisis calls. After an initial training that includes opportunities to rehearse responses to difficult questions, the teens

receive ongoing supervision and additional in-service training. In the future, UAY hopes to train youth to conduct intake interviews for their drop-in center.

YDI in Albuquerque also has had success in enabling youth to run various components, including theatre, music and arts groups and business enterprises. In addition, YDI hires former youth clients; several components, such as the Gang Intervention Project, are run by former clients.

Some agencies have instituted grievance procedures as another way of empowering youth. At **SDYCS'** The Storefront, for example, a youth's complaint is heard first by a case manager; if the issue is not resolved at that level, the youth may meet with the Manager of The Storefront and then go on up the ladder to the Executive Director of SDYCS, who has the final authority to arbitrate disputes between clients and staff.

A number of the programs expressed interest in utilizing youth more often for peer education and peer outreach. Some programs, such as **YDI** and **UAY**, have been particularly effective in this area through youth theatre and music groups. However, generally speaking, programs expressed a need for better training methods and techniques to encourage youth involvement.

CHAPTER VI.

FUNDING

ISSUES

Without exception, all the programs we visited cited a secure, dependable funding base as their major unmet need. Program administrators told us of the continuing anxiety that affects all program staff—not just administrators—as a result of fiscal problems that include:

- The one-year funding cycles of many state and federal agencies that make multi-year planning impossible;
- The proclivity of many private foundations to fund only new and innovative program components, and not ongoing operations;
- The difficulty of securing funds to cover general operating expenses;
- The inability to hire and retain competent staff when salary scales are low and positions are funded for one year at a time;
- The categorical nature of state and federal grants that makes it difficult to provide holistic services;
- The absence of available funds for certain critical program components, such as follow-up, training and evaluation, that are essential to maintaining high quality services; and,
- The detrimental effect of short-term funding on treatment that cannot be completed within the allotted number of days or units of service.

The program directors we interviewed described more competition for funds over the past decade, as the pool of available funds has shrunk. They cited a marked decline in federal grants, which recent research corroborates. Salamon (1989), for example, reports a 40% decline in federal support for social services from 1980 to 1986.

Some programs also cite a decline in United Way funding and a continuing tendency on the part of United Way to support programs that may be less controversial than those that serve runaway and homeless youth. While some states and local jurisdictions increased funding for social services in the early to mid-1980s, principally in response to federal "load-shedding" (Bendick, 1989), most program administrators are worried about the future of state and local funding. Many states already are experiencing serious budget deficits; with economies beginning to falter, other states anticipate similar cutbacks.

The funding constraints of the last decade have occurred at the same time that demand for services has increased. Stern and Gibelman (1990) point to a number of demographic factors and social trends that have led to increasing demands on service providers, including the growth in single-parent families, rising poverty, substance abuse and unemployment in inner cities, and the emergence of newly recognized populations, such as the homeless and persons with AIDS.

Our site visits confirmed these findings. In particular, we were told of the increasing pressure: to serve adolescents and young adults who now seek help at adult shelters; to provide housing to teen mothers and their babies; to provide mental health and substance abuse services; and, to assume more of the responsibilities of state child welfare agencies. Adding to the anxiety at nonprofit agencies is the recognition that the major public systems—child welfare, mental health, juvenile justice, health and substance abuse—also are overburdened.

In a few of the states we visited, there are promising trends toward utilizing public dollars more effectively for youth services. For example:

- Seattle's juvenile justice system supports an array of community diversion programs to reduce the number of youth in costly detention facilities. The state mental health system is involved in efforts to create more community based alternatives for youth, and the substance abuse system plans to develop badly needed adolescent treatment programs. (However, Washington State voters defeated a recent ballot initiative to raise taxes to support an increase in annual spending on child and youth programs, confirming the feeling of many program providers that the average citizen does not realize the full scope of service needs.)

- California has placed a tax on tobacco that is used to fund the Child Health and Disabilities Prevention Act, which allows doctors to bill the state for medical screening services for children and youth, including eye and dental examinations. Health screenings performed on-site at The Storefront are funded under the auspices of the Act.

- Iowa has created a statewide Decategorization Initiative, which has a mandate from the state legislature to utilize state funds to underwrite comprehensive services for children and youth at risk. For example, child welfare funds can be used to provide discretionary, "wrap-around" services to prevent residential placement.

In addition to the instability and inadequacy of funding, programs express concern over the burden posed by grant application and reporting requirements. While diversity of funding sources is a mainstay of fiscally healthy agencies, diversity creates a great deal more work for agencies. Each funding source has its own application and reporting requirements, timetable and funding cycles. Program administrators contend that government funders, especially at the federal level, do not allow sufficient lead time for submission of applications, that constraints imposed in some instances on use of funds are unrealistic, and that reporting requirements for some programs, such as the Job Training Partnership Act, are onerous.

Executive directors at several sites were concerned about the amount of time they devoted to fundraising, grant writing and public relations, at the expense of other important functions. Functions often "sacrificed" included: maintaining a close familiarity with staff and their problems; frequent visits to program components to maintain familiarity with changing client needs; close observation of staff and client interaction to ensure consistent quality; and, finally, time to be reflective and creative.

All of the programs cited a need for a stronger fundraising capacity, but most have not fully resolved the extent to which fundraising should be the responsibility of: the board, the executive director, a designated staff person whose only responsibility is fundraising, line staff who add fundraising to their other responsibilities, or some combination of these.

At the time of our visit, only three programs—YouthCare, Bridge and San Diego Youth and Community Services—employed full-time, professional fundraisers. A number of programs are

reorganizing their Boards of Directors to strengthen the capacity of the Board to raise funds. A few of the programs are currently trying to link long-range program planning with long-term financing strategies, and all of the programs cited a need to do this. The danger of creating program components simply because dollars are temporarily available to support them is well known to program administrators, who are often faced with the unenviable task of "buck chasing" to meet payroll.

VIABLE STRATEGIES

All of the programs we visited draw on multiple funding sources, tapping into a broad array of federal, state, county and city funds, in addition to private dollars, to support comprehensive services. **Youth Development, Inc.** in Albuquerque provides one example of these diversified funding sources. Its major service components are funded by the following multiple sources:

Education:

- *Stay-in-School Dropout Prevention Program* is funded principally by the federal Job Training Partnership Act (JTPA); county Community Development Block Grant funds subsidize a small number of youth who do not meet JTPA's income eligibility standards; some funding also is provided by a private foundation, and the Albuquerque Public Schools provide in-kind support, including telephones, school supplies, and duplicating equipment.

- *GED Prep/Entry Employment Program* (state accredited alternative education program) is funded by JTPA.

Employment:

- Youth Employment components of Stay-in-School and GED Prep Programs are principally funded by JTPA.

- *Summer Youth Employment Program* is funded by the Private Industry Council.

- *Youth Employment System* (youth enterprise operations) is partially self-sustaining and partially subsidized by general operating funds.

AIDS Prevention:

Project De SIDA (HIV prevention and education for Hispanic IV drug users and their families), *AIDS Education* (prevention program for high-risk youth), and *AIDS "Train the Trainers" Project* all are funded by state AIDS monies and the federal Centers for Disease Control (CDC); CDC funds are channeled through the Public Health Division of the State Health and Environment Department.

Residential:

- *Muchmore House* (residential treatment facility) is funded principally by the state mental health agency and in part by the state child welfare system.

- Housing for teen mothers and babies has received a federal Housing and Urban Development (HUD) grant and city housing agency funds to renovate HUD re-possessed housing, subsidize rents through the federal Section 8 program, and provide support services.

- *Amistad Emergency Shelter* (runaway shelter) is funded by federal Runaway and Homeless Youth Act and New Mexico's Children's Shelter Care Act funds.

- *Casa Nor Este* (transitional housing for chronic runaway youth) utilizes a building leased to YDI by the state for $1 a year; the program is funded by the State Department of Human Services.

Juvenile Justice:

- *Institutional Diversion/Community Corrections Program* (pre-sentencing alternatives for delinquent youth) is funded by the state juvenile justice system.

- *Gang Intervention Project* is funded by federal Office of Human Development Services, Administration of Children, Youth and Families, Department of Health and Human Services and revenue from the Mayor's Charity Ball in Albuquerque.

Prevention and Outreach:

- *Project Poder* (outreach and substance abuse prevention and education in housing projects) is funded by the Albuquerque Department of Housing.

- *Teatro Consejo* (substance abuse prevention and education with high-risk youth) is funded by the federal Office for Substance Abuse Prevention (OSAP).

- *Alamosa Community Center* (housing project drop-in center, outreach to community) is funded by the Albuquerque Housing Authority and the Parks and Recreation Department.

YDI also receives significant contributions from corporate and private donors and holds several fundraising events during the year.

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Bridge in Boston has a restricted donor endowment to support the periodic purchase of a vehicle for its medical van, a mobile medical facility providing outreach and health services to street youth (see Medical and Dental Care Section). Restricted donor endowments are a particularly effective way to fund specific program components.

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At **YouthCare** in Seattle, the professional on staff who is responsible for the agency's fundraising and public relations is called a Community Development Manager. He is primarily responsible for managing non-governmental grants; program staff and the Executive Director continue to write government grant applications. The Community Development Manager oversees fundraising events, YouthCare's annual and other direct mail campaigns, its newsletter, brochure, foundation and corporate giving, public service announcements and billboards, public speaking engagements and capital grants (governmental and non-governmental).

YouthCare's fundraiser is a member of the agency's management team, which meets weekly. As the agency has become more comprehensive and complex, there has been an effort to "centralize" and better control its media relations; rather than having individual staff deal directly with the press, the fundraiser serves as media liaison, handling all press inquiries. To stay grounded in program operations, he is on-site at program components at least once a month. He has a background in events management, public relations and writing, and a knowledge of the youth services field.

YouthCare holds two major fundraising events a year. The most lucrative of the two is a luncheon (now in its sixth year) to which leading members of the business community are invited; one or two key business people take a leading role in ensuring that their colleagues attend. Tickets are $100 per person. In 1989 the luncheon raised about $20,000; YouthCare's goal is to raise $100,000 a year from the luncheon. The second event is a musical evening and auction at Seattle's aquarium, which the city makes available at a low nonprofit rate. About 30 caterers donate food and advertising for the event, which raises between $10,000 to $15,000 and attracts new prospective donors that are added to YouthCare's mailing list. While benefits are a good source of unrestricted funds and public relations, YouthCare's fundraiser cautions that they are very time-consuming to manage.

YouthCare's annual campaign consists of a direct mail solicitation to about 4,000 individual donors on the agency's mailing list (all of whom have either given in the past or have expressed interest in the program). About 1,800 donors respond to the annual campaign, raising about $30,000. In addition to the annual campaign, YouthCare sends out one "cold" mailing a year, using a purchased list, which yields about a 1% return. YouthCare also sends out a newsletter on a quarterly basis to those on its mailing list, in which it includes a donation envelope.

YouthCare's fundraiser works closely with program staff to identify program needs suitable for foundation proposals. YouthCare applies to as many as 30 national and local foundations a year and has about six or seven proposals funded. A concern expressed both by program staff and the fundraiser (not only at YouthCare, but at many of the programs we visited) is the tendency of foundations to fund only new and innovative components when there is a far greater need for general operating funds, especially to compensate for the federal cutbacks over the last decade.

YouthCare stresses the importance of coupling fundraising with public relations and public information. Its public relations initiatives include television and radio public service announcements, public speaking engagements, a newsletter, a brochure, and a recently initiated billboard "advertising" campaign. Ten billboards were donated to the agency for six months.

YouthCare tries to utilize United Way events as the focus for speaking engagements. Like many programs serving runaway and homeless youth, YouthCare perceives United Way as preferring to fund less controversial, more mainstream programs. By making a concerted effort to educate United Way givers, YouthCare hopes to dispel the stigma that surrounds the population it serves. Last year, YouthCare staff spoke at 32 United Way functions. United Way's contribution, at present about $150,000 a year, makes up 9% of the agency's budget.

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The Iowa Homeless Youth Center (IHYC), has the advantage of being one component in a large nonprofit corporation. As a result, a number of essential services, such as bookkeeping and accounting, a consulting psychologist (who evaluates youth at IHYC), and weekly staff supervision are provided and underwritten by the parent organization, Youth and Shelter Services (YSS). YSS also retains a full-time grant writer who, along with the Executive Director, shoulders some responsibility for raising revenue that underwrites some IHYC expenses.

YSS has established its own foundation, which provides support to all 12 programs in its network, including IHYC. The YSS Foundation underwrites the kinds of expenses that traditional funding sources shy away from, such as: emergency money for homeless youth (to help youth on IHYC's waiting list buy food stamps, for instance); loans to help youth meet independent living expenses; and, rent and security payments for IHYC's independent living apartment program. These "discretionary monies" will be augmented by a $400,000 fundraising campaign, undertaken by IHYC's Advisory Board; the interest from $100,000 of this fund will be set aside as an endowment for "unfunded special needs", including increases in staff salaries. IHYC also is fortunate in having received multiple-year funds to cover general operating costs from three sources: The United Way, The Junior League and The Mid-Iowa Health Foundation.

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United Action for Youth (UAY) in Iowa City, to keep costs down, shares a building with two other youth programs: The Mayor's Youth Employment Program, which provides subsidized

jobs for disadvantaged youth, and Youth Homes, Inc., which provides emergency shelter, group homes, supervised independent living apartments and day treatment. The three programs also share the cost and use of a van, computer hardware and a receptionist. These shared resources not only cut down on overhead, they also promote close collaboration among the three programs, which readily utilize (rather than duplicate) each other's services.

In 1989, the three programs decided to expand their collaboration to include fundraising. To limit both the time invested in fundraising and the inevitable competition for contributions, the three agencies created a fourth entity, the Youth Service Foundation, that has only one function: to raise money. The Foundation is staffed by the Directors of the three agencies, who each devote five hours a week to Foundation activities.

To ensure that the Youth Service Foundation remains faithful to the mission of its founding agencies, it is governed by two boards: a Board of Directors composed of Board members from each agency; and, a Board of Trustees composed of leading citizens and members of the business community. At the end of two years, the Foundation's effectiveness will be evaluated and a decision made about extending its tenure.

United Action for Youth, like virtually all of the programs we visited, enjoys both the respect and the financial support of local public officials. As a result, UAY receives an annual unrestricted grant of $68,000 from the County Board of Supervisors "to cover cash flow", and a similar grant of $45,000 from Iowa City. To justify the $40,000 grant, which comes out of Community Development Block Grant funds, UAY must document that it serves low and middle income youth. Despite this $140,000 in unrestricted funds, UAY, like most of the agencies we visited, continues to have a "cash flow" problem.

All youth-serving organizations in Iowa City, including UAY, benefit from a unique, time-saving grant application process instituted in 1977 when Iowa City, Johnson County, the Coralville and Johnson Boards of Social Welfare and The United Way combined their application process and developed a single application form. At the same time each year, 45 agencies complete identical applications when applying to each of these funding sources. This unified process allows

the grant-making agencies to assess needs and resources in the community as a whole rather than piecemeal. Providers are convinced that the system saves time, promotes collaboration and diminishes unnecessary duplication of services.

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The Storefront, the Bridge and the Gatehouse—all components of **San Diego Youth and Community Services**—each receives funding from city, county and state contracts, but none of these programs can operate solely on public funding. The Storefront requires $200,000 in additional monies annually; the Bridge and the Gatehouse require an additional $90,000 to break even. Energetic private-sector fundraising and in-kind donations make up most of the difference. In addition, part of the deficit in each of the group homes is reduced by a sliding scale fee charged to all parents of children referred under their Community Action Program contract. The fee, which entitles parents to at least four family therapy sessions during their child's two-week stay, and as many as eight sessions more during the six-month follow-up period, also sends a "message" to parents emphasizing their responsibility for their child's treatment. In addition to the sliding scale fees, the Gatehouse receives an annual United Way donation of $60,000.

SDYCS, like the other programs we visited, receives funds from a myriad of local and national foundations, corporations and individual contributors. A most unique source of funds, however, is its Annual Celebrity Auction which, in 1990, raised a total of $55,000. SDYCS held its first celebrity auction in 1987 when a volunteer came up with the idea of soliciting personal memorabilia, such as instruments, clothing and sheet music, from entertainment figures. Dubious at first, SDYCS granted their volunteer the use of a long-distance telephone line. With telephone calls and announcements in entertainment trade journals, she acquired such items as Paul McCartney's autographed guitar (which sold for $5,000) and a shirt that Madonna wore in a music video. Now that the Auction has become well-known among serious collectors, many attend from all over the country. For SDYCS, the Auction has become not only a dependable source of funds, but also an invaluable source of good publicity.

CHAPTER VII.

INTERAGENCY COLLABORATION

In the decade ahead, as limited resources continue to inhibit program expansion, public and private agencies serving high-risk youth can expect to become increasingly inter-dependent. At each of the programs we visited, the challenge of providing a holistic spectrum of services with the scarce resources available has resulted in creative collaborative agreements, both formal and informal, with other agencies.

Many examples of interagency collaboration to develop or access specific program components are provided throughout **On Their Own.** This chapter addresses collaboration among agencies at broader systems levels.

VIABLE STRATEGIES

At the Agency Level

In Des Moines, representatives from 17 youth serving agencies, public and private, meet every six weeks to gripe, brainstorm and find solutions to their mutual problems. Shared cases, missing resources, successful treatment modalities, advocacy efforts and joint grant proposals are typical agenda items at these Special Needs Case Management Committee meetings, which were initiated by the Director of the **Iowa Homeless Youth Center.** The well-attended meetings have lessened the likelihood of distrust that can arise when agencies vie with one another for recognition and scarce funds.

The need to bring additional drug treatment, job training and medical services to street youth in Des Moines dominated the 1990 meetings of the Special Needs Committee. One notable result of the Committee's efforts has been the addition of an outreach nurse and medical supplies

to the Iowa Homeless Youth Center's street outreach team. The nurse, who rides the van once a week, is on the staff of a local hospital, Broadlawns Medical Center, and is also a member of the Case Management Committee.

SDYCS' The Storefront in San Diego utilizes a formal written contract and regular quarterly meetings to ensure smooth collaboration with 60 allied agencies. Participating agencies sign an operational agreement confirming their intention to cooperate in "the provision of the best possible assistance to San Diego's homeless, runaway and exploited youth population." In addition, agencies agree to attend quarterly meetings of what is called Project CAASE (Citizens Against Adolescent Sexual Exploitation). Signatories to The Storefront's operational agreement develop referral and service protocols. This interagency alliance expedites solutions when problems arise.

Similar to The Storefront's approach, Chicago's **Neon Street** utilizes written "barter" agreements with other agencies. For example, Neon Street has an agreement in place with Illinois Masonic Hospital for the provision of medical services for Neon Street youth; in return, Neon Street accepts referrals from the hospital for youth in need of shelter, crisis counseling or the other kinds of services Neon Street offers.

Neon Street has over 40 reciprocal agreements in place with social service agencies, hospitals, adult shelters, youth service agencies and others. They ensure services to youth who, as the program director notes, "otherwise would be forgotten as 'missed appointments' and 'not motivated'." None of the agencies to date has required fees for services. The director believes that programs not previously inclined to serve high-risk youth have agreed to do so for two reasons: with more of these youth ending up at their doorsteps, there is a need for agencies such as Neon Street to which they can refer; and, programs are more willing to serve adolescents knowing Neon Street will provide a back-up support structure.

On a more ad hoc basis, Albuquerque's **Youth Development, Inc.** (YDI) also barters services with other agencies. For example, the program negotiated with a nearby family health

clinic to provide a year of free health services to YDI youth in exchange for YDI's youth-operated painting crew to paint the clinic.

At the County Level

In Des Moines, the United Way of Central Iowa increased collaboration among the four principal funding sources in the county by creating the Human Services Coordinating Board. The Coordinating Board, which includes a representative from the United Way, as well as city, county and state agencies, has its own Director, who regularly reviews county programs and grant proposals. The Board adopts funding policies that guide each of the member agencies, ensuring a cost-effective continuity of essential services for children and adults. Although service providers do not attend these meetings, they benefit from the Board's commitment to comprehensive services for high-risk children and families. Recently, for example, when two homeless shelters were threatened with closing notices, the Coordinating Board assembled a consortium of funders that kept the shelters open.

Also on a county level, San Diego's County Commission on Children and Youth has formed a committee that meets monthly to evaluate health, mental health and education programs for homeless children and youth. The Committee collaborated with San Diego's departments of health, mental health and education to develop a survey designed to determine the unmet service needs of school-age children and youth, particularly those who are homeless. Results of the survey are being used to revise the location and allocation of county services, to heighten community awareness and to garner public support for policy changes.

At the System Level

Throughout this monograph, there has been discussion of the problematic nature of the connections between public service delivery systems and alternative youth services agencies. Two public systems warrant particular attention here because, historically, they have had mandated responsibilities for serving runaway and homeless youth. These are the child welfare and juvenile justice systems.

Child Welfare

The child welfare system has long been criticized by practitioners and researchers as failing to serve runaway and homeless youth. In part, this failure stems from child welfare's traditional orientation toward serving younger children, rather than adolescents (Kamerman and Kahn, 1989).

Although national and state policies over the last decade have been explicit in mandating child welfare to serve adolescents, these policies have not been accompanied by sufficient funds to ensure implementation (U.S. House Select Committee on Children, Youth and Families, 1989). The federal Child Welfare and Adoption Assistance Act of 1980, with its emphasis on family reunification and permanency planning, has been consistently under-funded. Similarly, in the late 1970s and early 1980s, many state measures were passed that decriminalized status offenders and transferred responsibility for runaway and homeless youth from juvenile justice agencies to child welfare systems without adequate funding (Boyer, 1988).

In recent years, with increasing demands, child welfare systems have become even more disinclined to serve adolescents. Staff at all of the sites we visited, as well as recent literature, describe the child welfare system as being "overwhelmed" (Kamerman and Kahn, 1989; Ooms, 1990):

- Workload demand as measured by reports of abuse and neglect has increased by 60% since 1980 (Kamerman and Kahn, 1989);
- Children and families are coming to the attention of the system with far more severe and multiple problems; increasing numbers of younger children, including infants, are involved in neglect and abuse reports (U.S. Select Committee on Children, Youth and Families, 1989); and,
- Problems of substance abuse and homelessness are adding to child welfare caseloads.

Child welfare systems today are able to respond primarily to children, particularly young children, who are in life-threatening situations; children, and especially adolescents, experiencing chronic neglect, school or community problems are often excluded due to shortages of staff and resources. In every city we visited, practitioners agreed that child welfare was "deflecting"

adolescents, often as young as 13 years old. In particular, there are enormous service gaps for 16- to 18-year-old male adolescents, and homeless youth over age 18.

Practitioners expressed concern that the system envisioned when status offenses were decriminalized was never operationalized. In Seattle, for example, child welfare was to have created a network of crisis residential centers to provide short-term emergency shelter. Instead, these centers today are clogged with "hard to place" youth in foster care. In Chicago, a network of so-called "1500" agencies was created to provide emergency shelter for runaways. While these agencies do serve runaways who can be reunited with their families, they have not been able to adapt to serve chronic, older runaways or homeless adolescents. In other cities, traditional group homes were expected to accommodate runaway and homeless youth, but the traditional group home structure does not work well with runaway and homeless youth and, in most cities today, group home vacancies are at a premium.

Practitioners also report that child welfare systems are doing a poor job of recruiting specially trained foster families, particularly for multi-problem adolescents. In addition, foster care rates are too low to attract specialized foster parents; foster parents do not receive adequate training or supervision; and, traditional foster care does not work well with chronic street youth, who are used to independence, do not wish to be parented and have many unresolved family issues.

In several of the cities we visited, child welfare systems are trying to provide more preventive family-based services to keep children out of the system. While practitioners serving runaway and homeless youth believe this is a positive trend for most youth and families, they are afraid that it may cause additional problems for homeless youth. In Seattle, for example, youth and families in crisis are diverted to the state child welfare system's Family Reconciliation Services (FRS) Program, which provides short-term, 15-hour, in-home crisis intervention designed to keep families intact. While FRS enjoys a reported 70% success rate in preventing out-of-home placements, both child welfare and YouthCare shelter staff report that it is not working for most of the population served by YouthCare—either because family reunification is not an option for homeless adolescents or, because more long-term family work is needed than the 15 hours FRS

provides. Because FRS is funded, not with new monies, but by shifting dollars from residential care, practitioners say it has aggravated the bed shortage, further backing up the system for youth who do require out-of-home options.

Most of the programs we visited complain that they have become a "dumping ground" for the child welfare system's unwanted adolescents. Some, like Bridge in Boston, consciously do not enter into formal agreements with child welfare, believing that they will lose options for open intake to the services they provide. Most of the programs have no formal agreements in place with child welfare. They are relating to child welfare primarily on an individual worker basis, across different child welfare area offices, each with its own idiosyncratic policies and personnel. While individual relationships may be excellent, there is no systemic integration or coordination between child welfare and most of the alternative youth services agencies we visited.

YouthCare in Seattle is one of the few agencies we visited that does have a successful agreement with the state child welfare system to provide transitional living services, through YouthCare's *Threshold Program,* for 16- to 18-year-old emancipated females who have a history of sexual abuse and are involved in or at risk of prostitution. The young women whom Threshold serves are "system failures"—youth for whom traditional child welfare programs have not succeeded. While technically these teens must be in state custody and be referred by the state to Threshold, in reality, YouthCare and the state have managed to build the flexibility into their relationship that often is missing in service arrangements with the child welfare system. The Threshold program is described in detail in the housing section of Chapter IV.

Juvenile Justice

Prior to the mid-1970s, runaways, whether they were involved in illegal activities or not, were treated as juvenile offenders and usually were incarcerated. With passage of the federal Juvenile Justice and Delinquency Prevention Act in 1974, and the numerous state juvenile code changes that followed, status offenses, such as running away, were decriminalized. In most jurisdictions, it is no longer permissible to lock up an adolescent simply for running away (although the practice does continue in some areas). However, most street youth are involved at some point

with the police and juvenile court system, if not because of their runaway status, then because of their involvement in illegal "street survival" activities, including drugs, prostitution and theft (Boyer 1988).

Many of the programs we visited have solidified relations with the police and juvenile court system. Some also have developed diversion programs designed for homeless youth, as an alternative to traditional diversion programs which require a family or community network. Staff indicated that diversion programs are particularly valuable to runaway and homeless youth, whose feelings of failure are heightened by involvement with the juvenile justice system. Often, juvenile justice systems also want to divert youth because detaining them is costly. Thus, it is frustrating for both when specialized services, such as substance abuse and mental health treatment, can be accessed only if a youth is formally court-involved.

YouthCare in Seattle, which specializes in working with juvenile prostitutes, provides outreach to youth in detention who have been picked up on solicitation charges. A master's level case worker spends about 20 hours a week at the county detention facility, intervening in individual cases and conducting group sessions. Whenever possible, youth are diverted to YouthCare's programs. YouthCare is on 24-hour call to detention to evaluate and, if possible, place youth. The county's Department of Youth Services (DYS) funds the 24-hour crisis response capability and pays for two beds at YouthCare's emergency shelter. YouthCare has had a contract with DYS for about four years, but provided many free services prior to that time to build good will and trust.

In addition to diversion services, YouthCare also provides AIDS education and prevention services on a daily basis to youth in detention. YouthCare also conducts in-service AIDS prevention and other kinds of training for DYS staff.

Both **United Action for Youth** (UAY) in Iowa City and **Youth Development, Inc.** (YDI) in Albuquerque have contracts with their respective youth authorities to provide detention alternatives for first offender youth charged with non-violent delinquent acts, including burglary,

possession of controlled substances and theft. These components tend to serve youth living at home, however.

Runaway and homeless youth programs offer an important option—often the only option—for police when they pick up a youngster on the street who cannot return home and whom the child welfare system will not take. Most of the programs we visited have agreements in place so that police departments will automatically refer runaway and homeless youth to them. The programs, in turn, have a 24-hour response capability, ensuring that a staff member will be available at any hour to come to the station and meet with a detained youth. Confident that program staff are competent to accompany teens to a shelter, devise a treatment plan and notify parents within the specified time period, police and probation officers have become a major source of referrals.

Relationships between runaway and homeless youth programs and the police take time and a concerted effort to develop. **SDYCS'** The Storefront in San Diego, for example, provides monthly updates and in-service training to the police department's juvenile administration officers. These regular meetings have dissipated much of the distrust that existed between the two agencies; as a result, policies have been developed which help to avoid conflicts that had been chronically troubling. For example, Storefront staff and juvenile officers have determined what constitutes appropriate behavior in those instances when police must enter the shelter to carry out a "hot pursuit" search. YouthCare staff suggested a series of steps for improving relations between police departments and runaway youth programs. These include: frequent communication and orientation; designation of specific liaisons at both the programs and departments; regular meetings between liaisons; development of an agreed-upon referral procedure; and, a 24-hour on-call system.

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The above examples illustrate only a few of the many potential benefits of interagency collaboration. Others include:

- The increased likelihood of obtaining needed funds when agencies cooperate rather than compete for grants;
- The creation of a network of complementary, rather than duplicative, programs;
- The availability of cost effective, multi-agency staff training, ensuring continuity across agencies and improved standards of care community-wide;
- The ability to share the difficulty of serving multi-problem youth, lessening feelings of helplessness, isolation and burn-out;
- The political strength of a broad-based advocacy coalition;
- The opportunity to adopt innovative strategies that have proven successful at other agencies; and,
- The ability to create a costly new resource (such as The Orion Center in Seattle, or the Volunteer Project in San Diego) by pooling funds and staff from several agencies.

Although interagency collaboration brings undeniable benefits both to individual youth and to the community, it is not easy to accomplish (Boyer, 1988). Collaboration takes time, energy and effort; overworked line staff cannot be expected to "find time" to meet with staff from other agencies unless such collaboration is an established part of their workload, not an extra-curricular activity. Collaboration requires shared values, shared goals, a shared vocabulary, tact and careful attention to the process by which agreements are reached. It is important to acknowledge that not all disagreements can be resolved; sometimes the best tactic is to tolerate (and respect) diversity.

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APPENDIX A

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LIST OF PROGRAMS

Bridge Over Troubled Waters
147 Tremont Street at West
Boston, Massachusetts 02111
(617) 423-9575
Executive Director: Barbara Whelan

Iowa Homeless Youth Center
(Youth & Shelter Services, Inc.)
217 Eighth Street
Ames, Iowa 50010
(515) 233-3141
Executive Director: George Belitsos

Neon Street Center for Youth
1110 West Belmont Avenue
Chicago, Illinois 60657
(312) 528-7767
Executive Director: Michael Delia

San Diego Youth and Community Services
3878 Old Town Avenue, Suite 200-B
San Diego, California 92110
(619) 297-9310
Executive Director: Liz Shear

United Action for Youth
410 Iowa Avenue
Iowa City, Iowa 52240
(319) 338-7518
Executive Director: Jim Swaim

Youth Development Incorporated
1710 Centro Familiar, SW
Albuquerque, New Mexico 87105
(505) 873-1604
Executive Director: Augustine (Chris) Baca

YouthCare
1020 Virginia Street
Seattle, Washington 98101
(206) 328-0902
Executive Director: Vicki Wagner

YouthCare
HIV/AIDS PREVENTION CURRICULA
developed by Dr. Robert Bidwell
University of Washington Medical School
Adolescent Medicine Division
1988
Revised by Charles Price, Iris Coover, 1989

CLASS I

Student Learning Objectives:

To be able to .....

1. Describe the magnitude of AIDS in the nation and in our community.

2. Describe in simple terms what causes AIDS, its effect on the immune system and how this affects a person's health.

3. List the body fluids implicated in the transmission of HIV.

4. Decide what sex and substance use behaviors lead to the spread of HIV, and which do not.

5. Examine the role of non-intravenous drugs and alcohol in the transmission of HIV.

6. Describe ways to decrease the risk of transmitting HIV through substance use.

Materials Needed:

1. "Time line" showing the increasing numbers of people with AIDS.

2. Chart showing the statistics on HIV infection in Seattle/King County.

3. Video "The Best Defense"

4. Condoms

5. Tube of water-based lubricant

6. Box of paper tissues

7. Dental dam or 1 foot square of cellophane paper (Saran Wrap)

8. Bottle of bleach

9. Three cups

10. Pamphlet: "What You and Your Friends Need to Know About AIDS" (Seattle-King County Dept. of Public Health), "High Fashion" (YouthCare), "Using A Condom" (Washington State DSHS) referral sheet of youth oriented HIV AIDS and drug/alcohol services.

Time Needed:

One to one and one-half hours.

Agenda:

1. Introduce self and ask students to introduce themselves.

2. Explain course's purposes and relevance.

3. Briefly assess the groups knowledge.

4. Demonstrate statistical information (tape)

5. Show video, "The Best Defense".

6. Briefly discuss video's content, updating content where necessary.

7. Discuss HIV transmission as it is related to sexual behaviors.

8. Discuss HIV transmission as it is related to substance use behaviors.

9. Discuss ways in which transmission can be prevented or decreased in relation to sex.

10. Demonstrate condom/lubricant usage.

11. Discuss the role of non-IV drugs and alcohol in transmission of HIV and ways to decrease the risk.

12. Discuss the role of IV drug use and risk reduction.

13. Demonstrate needle/syringe-cleaning with bleach.

14. Allow several minutes for question and answer period.

15. Pass out pamphlets, and community resource list.

16. If more than a one session class describe next session (interview with person with AIDS):

anticipate and briefly discuss fears, anxiety, discomfort about this session.

Activities:

1. Introduce self (name, position, from what agency) and ask students to introduce themselves.

2. Explain the course's purpose and relevance.

   (a) Describe increasing numbers of persons with AIDS in the United States. A time line illustrates this dramatically. On a plastic ribbon place colored dots, each dot representing 1,000 people. Use different colored dots for each year: 1984, 1985, 1986, etc., with a final set of colored dots representing predicted numbers of cases to 1991 or beyond. The visual impact of unrolling this ribbon in front of the students is dramatic. (Drawing).

   (b) To bring AIDS "closer to home", visually display the impact on Seattle/King County by showing the HIV "iceberg" made of colored dots, each representing 100 people. Use different colored dots for persons with AIDS, persons with AIDS-related complex (ARC) and persons with asymptomatic HIV infection.* Describe the difference between the three groups in simple terms but remind students they are not distinct and separate groups, but represent a spectrum. Interpret the dots into real numbers for the students. Regarding the larger group of asymptomatic individuals, emphasize that while these individuals are infected with the virus, they are not ill. Most are young and are likely to be having sex with others. Very importantly, most have no idea they are carrying the virus and are therefore less likely to take precautions when they have sex or use drugs. Anyone who has ever had sex without a condom or shared needles could be one of these people and there is no way to know who they are. Therefore, to be safe we must take precautions with all our sex and substance use partners.

   (c) Mention that within the next few years it is likely that everyone in the class will know someone with HIV/AIDS, or know someone who knows someone with HIV/AIDS.

(d) Relate any personal experience with HIV/AIDS (self, family, friends, patients) if you feel this is helpful in making the subject of HIV/AIDS more immediate for the students.

(e) Discuss briefly each session's content:

Class 1: Basic Information

Class 2: Person-with-AIDS Interview

Class 3: AIDS-prevention poster-making

(f) "Not here to tell you what to do, but to give you all the important information so you can make your own choices."

3. Show video: "The Best Defense".

4. Briefly discuss videos essential messages:

(a) HIV is easy to prevent.

(b) HIV can be spread through unprotected sexual intercourse.

(c) AIDS can be spread through sharing needles.

(d) Anyone can get HIV/AIDS.

(e) You can talk to your partner about reducing your risk.

Take any question s about the video.

5. Discuss AIDS transmission as it is related to sexual behaviors.

(a) Elicit body fluids important in the transmission of AIDS (blood, semen, vaginal fluid).

(b) Point out that whenever those fluids pass between two people, there is a risk of transmission.

(c) Based on "(b)", ask students to decide the risks (none, some, a lot) of the following behaviors and give reasons why they decided as they did. Be sure and describe behaviors specifically and in everyday terms so students understand what is being spoken about. Also point out that most of these

behaviors (e.g., anal intercourse) are common to both heterosexual and homosexual couples:

-hugging/petting
-kissing on check or lips
-French kissing
-penis in vagina (vaginal intercourse)
-penis in mouth (oral sex; fellatio)
-penis in rectum/butt (anal intercourse)
-mouth on vagina (oral sex; cunnilingus)
-masturbation (jacking off)
-mutual masturbation
-hand or fingers in rectum (fisting)
-urinating (peeing) on or in someone

6. Discuss transmission of HIV as it is related to substance use behaviors.

   (a) Review again which fluids are important in the transmission of AIDS and which are relevant to substance use (blood).

   (b) Based on "(a)", ask students to decide the risks of the following behaviors and to tell why:

   1) Sharing a bottle of beer or pipe. (No direct risk, but surely substance use of any kind can lead to further experimentation, including "shooting up", and also causes one to have impaired judgment relating to sexual behaviors, condom usage and so forth.)

   2) "Shooting up" and using one's own needles. (Same dangers as #1.)

   3) "Shooting up" and using one's own needles with another person.

7. Have students suggest ways of preventing or decreasing HIV transmission through sex.

   (a) Abstinence

   (b) Decrease numbers of sexual partners

   (c) Engage only in "safer sex" activities

   (d) If engaging in penetrative sex, (vaginal, anal or oral), use barrier methods of protection (condom and dental dam).

8. Demonstrate correct condom and dental dam usage.

(a) Condom:

1) Use latex, not animal material condom. Use lubricated condom for vaginal and anal intercourse (non-oxynol 9 preferred).
Use receptacle-tipped to hold semen.

2) Add lubricant, inside and out, to increase sensation, decrease likelihood of breakage;
Use only water-based lubricant (e.g. K-Y or H-R jelly) DO NOT USE Vaseline, baby oil, Crisco, etc. They dissolve rubber!

3) Put on condom before any penetration (pre-cum, contains sperm and virus, it infected)

4) Pinch top 1/2 inch of condom to remove air in receptacle, place condom over head of penis and roll down to base. If condom is put on upside down (and is therefore unable to roll down) discard, as it will be contaminated with semen if turned over.

5) After intercourse, pull out while penis is hard. Otherwise, condom will come off inside other person during withdrawal.

6) Discard condom. **DO NOT REUSE.**

7) Condom is not 100% reliable, but has good reliability if used correctly.

8) Ask volunteer to put two fingers together to represent a penis, and demonstrate correct method of putting on condom. Then have students practice in pairs.

(b) Dental dam (cellophane wrap)-- used for oral/vaginal contact.

1) Buy dental dam if available, place over vaginal entrance to prevent direct oral/vulvar contact.

2) If dental dam is not available, use large square of cellophane paper or cut

open a condom to prevent contact of mouth with vaginal fluids.

9. Have students explore the ways non-IV drug use may enhance transmission of HIV and how to reduce the risk.

   (a) Ask student to think of a situation where they might have been involved in where they didn't want to participate, but did because they were high or drunk.

   (b) Explain the term "impairment of judgement"

   (c) Have students suggest ways that being impaired might put them at direct risk for acquiring HIV (sex or IV drug use)

   (d) Explain the effect of drugs on the immune system, the system effected by HIV.

      (1) If the immune system is low, cuts or sores may heal more slowly giving extra time for the virus to enter the body.

      (2) If someone already has HIV, drugs and alcohol can make that person become sick with AIDS more quickly.

   (e) Have students suggest ways of reducing non-IV risk such as not using any substance or getting help if you are having trouble stopping. If you are using drugs don't have sex or use needles or always carry a condom and/or bleach with you.

10. Have students suggest ways of preventing or decreasing HIV transmission through IV use.

   (a) If using needles, don't share them.

   (b) If you are reusing your own needle mark it to be certain that you aren't using someone elses or clean it with bleach anyway.

   (d) If sharing needles, clean them.
   - Discuss effectiveness of various methods -- flushing with air, water, alcohol and bleach.

11. Demonstrate needle/syringe cleaning with bleach.

   (a) Pour bleach into one cup, water into another. Have a third cup to discard used liquid.

(b) Suggest taking "rig" apart and soaking as long as possible ("ten seconds is better than nothing")

(c) Then put "rig" together, draw bleach through needles into syringe and push out twice. Rinse twice with water.

(d) Emphasize that some virus is still likely to be present, so using the needle is still risky.

(e) Let students practice individually.

12. Ask if any questions and answer briefly.

13. Briefly discuss feelings about next session in which a person with AIDS will be guest speaker.

14. Pass out pamphlets, Community AIDS Resource List (YouthCare).

CLASS 2

Student Learning Objectives:

To be able to ...

1. Have a better understanding of the human dimension of the experience of having AIDS.

2. Understand the connection between lack of knowledge, sense of invulnerability and exposure to HIV.

3. Examine and discuss feelings and opinions about persons with AIDS, gay persons, substance users and others who might engage in risk behaviors.

4. Ask others any questions or offer thoughts about AIDS, its medical and emotional aspects, and risk behaviors.

Persons and Materials Needed:

1. Person with AIDS, ARC, or HIV infection (or exposure).

2. "Iceberg" chart of HIV infection. (optional)

Time Needed:

One to one and one half hours.

Agenda:

1. Ask if any questions from previous session.

2. Introduce guest (person with AIDS) and have students introduce themselves.

3. Explain classes purpose and relevance.

4. Ask guest to briefly tell about him/herself. Then open session to questions from youth participants.

5. Discussion of student's reactions to the class.

6. Provide information on further information, counseling.

Activities:

1. Ask if there are any questions from the previous session; if none, let the students know that they may ask any questions that come to mind during the course of the hour.

2. Introduce the guest speaker (This may be a person with AIDS or other HIV infection.*) (e.g., "This is my friend, _____. I've invited him/her to come and talk to us about his/her experience with AIDS [ARC. etc.]." Then ask the students to introduce themselves briefly.

   * Ideally the PWA/ARC/HIV is young and has a history of substance abuse.

3. Explain the purpose and relevance of this session. (See Learning Objectives 1-4). Also let students know that all questions are fair, but that the speaker may decline to answer any questions he/she wishes.

4. Ask guest speaker to briefly tell about him/herself. Following this, the teacher may begin the interview by asking (for example): "What does it feel like to have AIDS [ARC, etc.]?", or "Do you know how you got the virus?" Then open up the session to student questions. Be sure that the aspects of having AIDS as well as touching again on modes of transmission and means of protection.

Examples of questions frequently asked:

"What is it like to have AIDS?"
"How has AIDS changed your life?"
"What was your family's reaction to your having AIDS?"
"What was your friends' reaction to your having AIDS?"
"Do you know how you got AIDS?"
"Did you know about AIDS when you practiced risky behaviors?"
"Do you still have sex?" "Is it 'safe sex'?"
"What are the symptoms of AIDS?" "What are the first signs?"
"How do you know if someone has AIDS?"
"Do you use drugs/alcohol?"
"Are you ever depressed?"
"Have you ever thought about suicide?"
"How did you feel when you first learned you had AIDS?"
"Did you know anything about AIDS when you were infected?"
"What kind of support do you get? (financial/emotional)".
"How can we help?"
"How do you feel speaking in front of a group like this?"
"How long ago were you diagnosed?"
"Have you ever been in the hospital?"
"How long do you think you will live?"
"Do you think there will be a cure before you die?"
"What kinds of medicines do you take?"
"Are you gay?"
"If you knew what you know now about AIDS, how would you have acted differently in the past?"

5. Ask students to share their feelings on how they felt before coming to class. Did they feel anxious, afraid or worried? How did they feel during and by the end of the class? (An opportunity for further discussion will be provided at the next session without the guest speaker present.)

6. Provide resource information on individuals within the institution and community agencies that can discuss individual student concerns. Also, let students know that you can meet with them individually to discuss general AIDS information and personal risk factors if they would like to do so.

CLASS 3

Student Learning Objectives:

To be able to ...

1. Analyze and decide what are the most important messages around AIDS, AIDS prevention and the experience of having AIDS.

2. Teacn other teenagers about AIDS in a creative manner through the medium of posters.

Materials Needed:

1. Various sizes of white and colored poster paper.

2. Variety of felt-tip drawing pens, colored and graphite pencils, pastels.

3. Straight-edges, pastels, French curves, compass for circle drawing.

4. Scissors, pencil sharpener.

5. Cardboard letter/number stencils (1" and 2") in various lettering styles.

6. List of spelling words.

7. Scratch paper for practicing slogans and drawings.

8. Examples of poster from previous session.

Alternative Activity:

1. Instead of, or in addition to the posters have youth write a letter to the PWA.

Time Needed:

One to one and half hours.

Agenda

1. Briefly discuss thoughts, feelings and questions about the previous session with guest speaker (person with AIDS).

2. Explain the lessons' purpose and relevance.

3. Discuss the kinds of messages that might be explored and show several example to the class.

4. Have students spend the rest of the session on posters with teacher guidance as needed or requested.
Let the youth know that messages may be in words or pictures or both. Both English and non-English posters are fine. Some degree of explicitness and or suggestiveness are often encountered in these teen group; this is acceptable if the message reflects accurate knowledge and is effectively instructional. Discourage any put-down or shock-for-shock's-sake. Display a sampling of posters made by other groups of teens.

   Encourage students to develop positive rather than negative or frightening messages (e.g., "Love your lover-- use a rubber" is more positive than "AIDS kills"). But let the student make the final decision on content.

5. Have students work on posters. Provide spelling list of frequently used words (AIDS, condom, protect, syringe, etc.) Also provide scratch paper so that students can work out slogans and drawings. Work with students, providing positive feedback and suggestions. Avoid censorship (e.g., Garfield the cat wearing a condom is great! It's simple, humorous and carries a most essential message, "wear condoms"). Help those students who have a difficult time thinking of a message-- give gentle suggestions, but don't force them to produce immediately. Some of the best posters are those thought up and developed in the last 20 minutes of class.

6. At the end of the hour , have the students display and briefly discuss their posters. Provide positive comments. If any students would like to have more time to work on their posters, give them this option if possible and arrange to pick up the poster later.

7. Briefly summarize the basic messages of the course:

   (a) HIV is easy to prevent.
   (b) Any sexual of substance use behaviors involving an exchange of blood, semen or vaginal fluid are risky.
   (c) Around both sex and drugs, abstinence is safest.
   (d) If sexually active, use a barrier method of protection

YDI - AIDS EDUCATION MANUAL
in
"Training of the Trainers Project"
AIDS Education/Risk Reduction Leader's Guide, YDI

INTRODUCTION

This section contains outlines for groups that can be held as follow-up to an AIDS Education presentation. The topics address underlying causes of high risk behaviors, such as anxiety, as well as behaviors associated with risk for HIV.

A number of these groups are educational in nature and are outlined for a didactic presentation. The majority, however, include questions which will generate discussion among the group members.

Although these groups are presented as single topics which can be presented alone, several of the topics work well together as a series as follows:

Five Year Plan, Low Self-Esteem, Responsibility, and Parenting

Responsibility, Sexual Activity, Self-Esteem, Birth Control, Sexually Transmitted Diseases, and Prostitution

Anxiety, Low Self-Esteem, Runaways, and Suicide

There are many combinations that can be made to develop a series; however, it is important to note that each group is able to stand alone in recognition of the fact that many agencies deal with a very transient population.

Those groups that include health information encourage the program to invite health professionals to present information or to consult with a physician in order to assure that the information provided is correct.

Whenever possible, the staff members who wrote these outlines were helped by the clients residing at Amistad. These young people were of enormous help.

ANXIETY

Purpose: The purpose of this group is to help clients become aware of what produces anxiety in their lives and how they can better deal with it.

I. Generate discussion: What are the signs of anxiety?

1. Tired
2. Nervous
3. Hyper
4. Uneasy
5. Depressed
6. Restless

II. Do you get anxious? What are some of the causes of anxiety?

1. Too much pressure
2. Worrying too much
3. Not enough rest
4. Procrastination
5. No physical outlets (exercise)
6. Peer pressure
7. Work pressure
8. Loneliness

III. Are there things that you can do to cope with anxiety?

1. Rest/Relaxation
2. Long term planning
3. Time away from work
4. Reading for relaxation
5. Writing (journal, diary)
6. Soft music
7. Time with/in nature (mountains, beach)
8. Fitness schedule

IV. Do we bring anxiety upon our parents, if so, how and why?

A. How

1. By constantly complaining or whining?
2. Constant bickering with our siblings.
3. Not following rules or orders
4. Getting involved with the wrong crowd
5. Drugs
6. By playing our music too loud

B. Why

1. Just because it's a part of growing up
2. We don't know any better
3. We don't care
4. Because they owe it to us

V. Do parents bring anxiety upon us, if so how and why?

A. How

1. By constantly yelling
2. By constantly fighting with one another (husband and wife)
3. Bringing their problems home from work
4. High expectations
5. A closed mind
6. No communication
7. Too strict

B. Why

1. Not meeting their own expectations of themselves
2. Work pressure
3. Bills

IV. How can we work together to solve this problems of anxiety?

A. More communication

B. Caring

C. More parent child interaction

D. More attention

E. More affection

F. More honesty (telling things like they are)

FIVE YEAR PLAN

Purpose: To help clients to understand the process of planning. Through this group, staff people may gain understanding about the client's logic process and views of reality and level of self-esteem.

I. Introduction: Go around the room and ask what they're going to be doing 5 years from today. Be careful not to be judgmental about what the clients may suggest they want to be -- the main point here is to help them understand the process of planning.

II. What do you see yourself doing 5 years from today?

A. Discuss each individual career chosen

B. Is that something realistic that you can accomplish in 5 years?

C. What steps need to be taken?

D. What might be some possible difficulties you might encounter

1. Health (bad)
2. Lack of money

E. If you have some problems, how will you deal with them?

III. If the clients career goals are very unrealistic, at the end of discussion it might be good to bring them back to reality in a gentle way

LOW SELF-ESTEEM

Purpose: To establish a better understanding of oneself and those around you. To establish a better understanding of one's value in life. To gain a better understanding of oneself and learn to be more sensitive to those around you. A better sense of humanity. To begin to understand low-self esteem as a temporary condition that is manageable.

Content: The main emphasis will be on understanding various cause of low self-esteem and how this lack of self-esteem can affect many other situations.

I. Generate discussion about the following questions: Who develops low self-esteem? NOTE: This question is intended to convey to clients that many people get a low self esteem at varying times - not just teenagers.

A. What does low self-esteem mean? What does it feel like?

1. Characteristics
   a. Not confident
   b. Insecure
   c. Tends to be very much to oneself
   d. Anti-social
   e. At times argumentative
   f. Sometimes suicidal

B. How do people get a low self esteem?

Contributing factors:

1. Not given enough attention as a child
2. Little recognition
3. Little affirmation
4. Neglect
5. Physically or sexually abused as a child
6. Position in family (e.g. middle child in a family of eight)
7. Home environment
8. Social environment
9. School environment
10. Learning skills (slow)

II. How do people react to other people who are down on themselves?

A. Worthless

B. Weak

C. Useless

D. Unsuccessful

E. No future

F. A bum

G. Pity

III. What do you do about those reactions we just mentioned?

What are some of the positives things we can do? What are some of the negative things we can do?

A. More positive attention

B. Affirmation

C. More recognition of accomplishments

D. Providing them with an emotional safe environment

1. Where one can experience both success and failure and still feel good about yourself
2. Where one can realize that hurting yourself or your body physically does not make you feel better about yourself
   a. Drugs
   b. Prostitution
   c. Self-mutilation
   d. Suicide (attempts)
   e. Promiscuous (looking for some attention)

E. Using low self-esteem or reactions as an excuse not to succeed.

PROSTITUTION

Purpose: To focus on understanding factors which may contribute to adolescents falling into this type of exploitation. Discussion of dangers with regards to AIDS.

I. Incidence of prostitution

A. 1/4 - 1/2 million in U.S. Who do you think these people are?

II. What do you think prostitutes are like ?

Characteristics of prostitutes

A. Typically from broken homes

B. Usually victims of sexual abuse

C. Experienced school problems/truancy/bad grades

D. Low self-esteem

III. Other factors

A. Many chronic teenage runaways may turn to prostitution as a means of survival

B. I.V. drug use is prevalent among prostitutes

C. Prostitutes are at high risk of contracting STDs or AIDS

1. Poor/improper use of birth control
2. Sexual activity with numerous partners
3. Sharing of needles for I.V. drug use

IV. Generate discussion: Could you be at risk for becoming a prostitute/by becoming a prostitute?

V. Encourage the clients to explore some of the dangers associated with running away i.e. homelessness, and becoming involved with people who are willing to exploit you.

RESPONSIBILITY

Purpose: The group will first discuss and clarify the literal meaning of the word responsibility and how it compares to how most adolescents perceive it.

I. Introduction: You've probably heard the word responsible a lot. "You have to be more responsible. or It's time that you take some responsibility. What does that mean?

A. Is it easy to be responsible? What makes it hard?

1. Expectations too high
2. Peer pressure
3. An important difficulty is trying to be both responsible enough to meet parents' expectations and irresponsible enough to not be classified as a "goody two shoes"

B. Different people have different ideas about what responsibility means. (You may want to give a definition from the dictionary)

1. What are some of the situations that you've been in where you thought you were being responsible and someone else though you were being irresponsible?
2. Why was there a difference of opinion in this situation?
3. What could have been done to avoid or change the differences in that situation?

SEXUAL ACTIVITY - FORMING RELATIONSHIPS

Purpose: To have clients examine their understanding of sexual activity and explore decision making with regard to the relationships they have.

Group facilitator introduces topic and elicits group response on their perceptions of the subject matter. Facilitator, at this time, expresses what he or she understands sexual activity and forming relationships to be.

I. Introduction: Presentation of facts and figures regarding the prevalence of sexual activity among adolescents.

II. What are some common misconceptions regarding sexual activity?

- A. Can't get pregnant
- B. "If you love me prove it."
- C. "Everybody's doing it" - peer pressure
- D. "You're still a virgin?"
- E. Winning peer approval through conquest

III. Positive aspects to building relationships

- A. Communications
- B. Honesty
- C. Building trust
- D. Friendship before intimacy - What does intimacy mean to you? Does it always mean sex?

IV. Purpose

- A. To get group to think about whether or not being sexually active is necessary in forming an intimate relationship.
- B. To stimulate discussion/opinion of why or why not sexual activity is needed in an intimate relationship.

SUBSTANCE ABUSE

Content: The group will discuss factors underlying adolescent substance abuse; the dangers surrounding abuse, particularly I.V. drug use and contracting AIDS.

I. Introduction: Discussion of experimentation/social use vs abuse/addiction

A. Tolerance

1. Prolonged usage - higher tolerance
2. Tolerance high among adolescents
3. Signs of withdrawal ≠ evidence of addiction
4. Chronicity and frequency of use

B. Behavioral changes

1. Moodiness/mood swings
2. Anti-social behavior
3. Eating disorders

II. Factors indicative of potential substance abuse

A. Family history

1. History of abuse of substances in nuclear or extended family

B. School performance

1. Drastic changes in grades
2. Truancy
3. Disruptive classroom behavior

C. Legal issues

1. Drug or alcohol related offenses e.g. possession, driving while intoxicated
2. Escalation in offenses
3. Are offenses supporting drug habit?

III. Drug use in relation to AIDS

A. Use of substances put individuals at high risk to expose themselves to unsafe sex (lowers inhibitions)

B. I.V. drug use

1. Sharing needles
2. Using dirty needles

C. Inhalant nitrates

Purpose: To explore factors regarding substance abuse and to educate on dangers of I.V. use and getting AIDS

TEEN SUICIDE

Content: To make the client aware of the problem of teen suicide in today's society. Open some doors to themselves that they never knew existed. Give them some self-worth.

I. Introduction: What can be so bad that you would think of killing yourself?

- A. A death in your family
- B. A death of a close friend
- C. Nothing going right
- D. Loneliness
- E. Things would be better for everyone if I just weren't ever born

II. Signs of wanting to commit suicide

- A. Giving all your things away
- B. Depression
- C. Anger
- D. Carefree attitude
- E. Not caring about anything or anyone
- F. A sudden change in attitude and appearance
  1. Starting to wear black
  2. Getting interested in things associated with death

III. Causes of teen suicide

- A. Not enough love
- B. Not enough attention
- C. Lonely all the time
- D. Nobody to talk to
- E. People always putting you down
- F. Thinking that you might be doing parents a favor

IV. What would you say to someone who you knew was about to commit suicide?

A. At this point it would be a good idea to participate in a role play situation - either split everyone into two's or just you and a volunteer roleplay as a presentation

Purpose: The purpose of this group presentation is to bring out the seriousness of teen suicide in the U.S. today and ways that we can help others or get help ourselves.

PARENTING

Purpose: To generate discussion among clients about their perception of what parental responsibility is and to promote a better understanding about what being a parent entails. To help clients to examine their own roles as children in the process of parenting.

I. How many of you think you're going to be parents someday?

   A. What do you think are a parent's responsibilities? Discuss these ideas.

II. As a parent someday, what do you see as being the most difficult responsibility that you may have to face?

   A. Deciding appropriate discipline

   B. Role Modeling/teaching kids what's right and wrong

   C. Setting limits/knowing when to say no

   D. Not playing favorites among siblings

III. What are other responsibilities you would have as a parent?

   A. Taking care of the family - not just financially - but in every way.

   B. Communication/objectivity/allowing kids to express their point of view

   C. Educating kids about subjects such as sex and drugs

   D. Expressing love and affection

   E. Provide an emotionally comfortable home to live in

IV. How can you make your job as a parent easier?

   A. Develop a support system within your own family

   B. Develop a relationship with mutual respect and understanding with your children

   C. Spend time with family - be there - don't be too busy to talk

   D. Be honest with your children

V. Let's turn it around again. How can you - or any teenager - help parents to develop the skills we have talked about?

Close with this discussion

AIDS TRAINING OF TRAINERS SCHEDULE: DRAFT

Session	Process	Content
I. October 18	.**Needs Assessment**/Review 2.Team Building/Ice Breakers (AIDS theme) 3. Training overview review 4. Why we are doing this. 5. Pre-test	1. AIDS 101 -Introduction 2. Statistics on AIDS ....Video "Sex, Drugs, ..and AIDS"
II. Oct. 25 III. Nov 1	. **Defining the Training Population** 1. Intro to Adolescence 2. Adolescent Denial and Fears 3. Adolescents In Crisis 4. Affirmative Behavior (role plays) 5. Values Clarification 6. Instilling Perception of being "at risk" 7. Staff Burn-out	1.AIDS 101 -Transmission 2. Basic Sex Ed. 3. Teen Pregnancy 4. STD's
Oct/Nov. Meeting:	**Commitment for Phase II Training (Time) & Agency AIDS Policy?**	
IV. Nov. 8 V. Nov. 15	. **Training Population (cont)** 1. Envirnoment, Culture, Ethnicity (panel ..impact on sexual prac./sub. abuse discus.) 2. Staff comfort zones /barriers 3. Values Clarification 4. Instilling perception of being "at risk" 5. Affirmative Behavior (role plays) 6 Language Desensitization	1. AIDS 101 -Prevention 2. Sexuality Issues ..a. Hetero/Homo/Bisexuality ..b. Sexual Activity .3. Substance Abuse .4. Social Impact

VI. Nov. 22	**Training Population (cont)** 1. How to deal with sensitive situations ..(panels discussions) 2. Stress & Burnout	1. Disfunctional Fam. 2. Incest, Rape 3. Teen Prostitution 4. Sexual Identity Issues 5. AIDS Prevalence
VII. Nov. 29	. **The Role of the Trainer** 1. Issues of Fear and Anger re AIDS 2. What is a Facilitator? 3. Language use, to best communicate 4. Stress & Burnout	1. AIDS Resources 2. Personalizing AIDS 3. Counseling
VIII. Dec. 6	**Role of Trainer (cont)** 1. Communication Methods (Grp. process) 1.Agency Policy/Confidentiality 2. Lanugage during training (policy) 4. Enabling Prevention	1. Staff/Kids/Families 1. HIV Testing/Pros & Cons 2. Helping kids cope 3. Counseling methods 4. Condoms/Bleach Policy 5. Confidentiality Issues
IX. Dec. 13.	. **Teaching/Learning Principles** 1. Knowledge vs Attitudes vs Behavior 2. Empowerment methods 3. Speaking in front of a group 4. How to's of training/methods 5. **Mid-Evaluation**	1. How to change behavior? 2. Self-Esteem 3. Touchy issues

November Meeting: time taken during October meeting

X. Dec.20	. **Training Objectives/Develop Workbook** 2. Clarifying Staff & Youth roles in trng. 3. Writing objectives	1. Which AIDS issues?

December Meeting: Phase III Objectives and Plan/How to fit into Staff Training Design

XI. Jan 10	.**Evaluation & Design** 1. Determining if bahvaior has changed 2. Designing the trng evluation 3.Designing the Training Program 4. Session content, #, time, etc.	1. AIDS follow-up? 2. Which info will ..you use?
XII. Jan 17	1. Preparing for Training 2. Logistics, etc.	1. Resources
XIII. Jan 24	1. Training Practicum 2. Feedback	
XIV. Jan 31	1. Planning for Phase III 2. Phase III Objectives & Plan 3. Post-test 4. **Final Evaluation**	

January Meeting: Final Phase II Training Preparation/Discussion

EXPECTATIONS

These guidelines were written in conjunction with youth in the project. Copies of house rules and expectations for each phase, are also included.

House Meeting:

A house meeting occurs once a week, on a weekday, usually around 5:00pm. The meeting time is contingent upon people's schedules....we are flexible. We plan for a time that everyone can make. Each house member is invited to the meeting; it is also mandatory. Beyond house residents, the director of the program, the program caseworker and the two house staff are at the meeting as well.

Meeting Format:

*We sit comfortably in a circle in the living area (free of disturbances such as the T.V., phone and radio)

*For the first ten minutes, staff discuss agenda issues upstairs.

*House members have the first ten minutes or so to discuss issues among themselves, free of staff presence

*The meeting begins, usually lasting an hour.

*We provide an open forum. Each person is encouraged to talk and communicate to the group. In return, the group is encouraged and expected to offer their attention and respect to what is being said. Topics of discussion range from chores to personality conflicts to world politics.

Discipline

A lack of rigidity and increasing amounts of freedom are what we attempt to provide. These are privileges that each individual inherits with the Threshold program. But, what happens when a rule is broken? What happens when judgement is not the better part of valor?

We approach each program participant as an individual; in other words we do not have a set response for every conceivable disruption of the status quo. If someone has made a poor choice or broken a rule, above all, we ask for introspection. We ask the individual to examine her commitment to the Threshold program. If we decide to enforce a consequence, what we choose depends upon the situation. Restriction usually suffices. It provides for a time of reflection, reevaluation and general unhappiness. Restriction means no friends over, no free time, or basically house internment.

APPENDIX D - Excerpts from THRESHOLD HOUSE RULES

Chores

(A clean and lovely house around the clock)

The Philosophy:

We share a house. We share the responsibility to maintain the house. Each house member is expected to respect our home and its appearance; therefore each individual must willingly take part in the "grit work".

The Structure:

Each person (including the staff) chooses one night as their night to clean house. Their duties on that night include:

1. Washing and putting away the dishes

2. Cleaning and straightening the general living area (this includes dusting and vacuuming).

3. Cleaning the bathroom

* Two days during the week are not covered; therefore house members are expected to collaborate and make special efforts to clean after themselves on these nights.

* If an assigned day goes by without cleaning, $5.00 is deducted from the house activity fund and general displeasure with the lazy sacbutt runs rampant.

* If a staff member neglects her night, she pays $5.00 into the activity fund.

Room Sharing

Each Threshold participant has a roommate.

Room Rules...

No guests in bedrooms

Cleanliness is a virtue

No tacks or nails in walls, tape or wall putty only

No food or drink in bedrooms

A policy of mutual respect between roommates is encouraged. Roommates must work toward peaceful coexistence, which may lead to negotiating music tastes, waking hours, sleep hours, etc...

Education

The Minimum...

Each Threshold participant is expected to have or pursue her GED (General Educational Development).

The Philosophy...

We encourage furthering education for each individual. Whether it is an anger management class, an art course or enrollment in a community college, we emphasize intellectual growth and development of the mind as a way to empowerment. Schooling carries just as much weight as having and keeping a job.

* Financial Aid resources can be tapped when necessary.

* Each Threshold participant has access to an education advisor.

Grocery Shopping and Meals

Shopping...

The buzzword is budgeting--we shop with thrift and frugality possessing us. We run on a monthly budget for food, and the exercise of price consciousness is an important lifeskill. Generally one shopping trip is made per week. A staff member will trek to the grocery store with one or more house residents to do the shopping. The process requires help unloading and putting away the groceries once we have returned home.

Meals...

As a rule, each individual is responsible for her own meals. On occasion we have a house meal together. Often times two or more house members will collaborate in preparing an informal meal together.

Employment

A must...

Each youth is expected to maintain at least 1/2 employment while participating in the project.

Individuals are required to have a savings account and begin saving for the necessary items they will need upon graduation.

THRESHOLD PHASE I

EMANCIPATION GUIDELINES

CURFEW:

WEEKNIGHTS - First two weeks between 8:30 and 9:00pm
Second two weeks between 9:30 and 10:30pm
After that 11:00pm

Times are set with the understanding that:

1) Times are not to be overused or abused
2) These are the latest times they may return but are not automatic givens
3) These are the minimum lengths of time and may be extended if the individual has not demonstrated an adequate level of responsibility and stability.
4) Client is to establish with her Primary what time she will be returning home, where she will be and with whom
5) Check in calls are to be made as arranged

WEEKENDS - First two week by 11:00pm
Second two weeks by 12:00am
After that the possibility of 1:00am on specific occasions

Times are set with the understanding that:

1) Times are not to be overused or abused
2) Client does not expect to be out every night, every weekend
3) The times established when client is to be back home will be based on where client is going, with whom and the means of transportation

CONSEQUENCES:

1) First <u>two</u> times client is late returning (without a reasonable excuse and showing of responsibility), the time late will be deducted from the next night out. (i.e., one half hour late, return home one-half hour earlier the next time out)
2) The third time late the client reverts back to the first level for both weeknights and weekends. Later times will be reestablished as client is again demonstrating responsible and mature judgement. Minimum time is one week. If still at first level, those times will be set earlier.

BEDTIMES

First two weeks - follow short-term housing rules
Second two weeks - in bed between 11:00 and 11:30pm
After that may establish own bedtime

Times are set with the understanding that:

1) The client is responsible for getting up on time. It is not the staff's responsibility to make sure anyone is up to get to work and/or school on time
2) Client does not disturb others in the house as well as those in her room
3) Client follows house rules on use of downstairs after 10:00pm.
   - must have permission to watch TV
   - phone calls are completed by 10:00pm
   - may use rec room as long as noise level is kept low and does not disturb those already in bed
   - must remain downstairs after rest of group has gone upstairs for the evening
   - dining room use is completed by 11:30pm
   - videos must be started early enough in the evening so that all clients can see the end
   - depending on circumstances in house clients may be asked to remain in their room

CONSEQUENCES:

1) If behavior of client disrupts others in the house and/or the client is not getting up in the morning, client will begin again with the original bedtime. Later times will be re-established when responsible behavior has been re-established.

CHORES

First two weeks - will have a daily house chore.
After that the client will have the choice of doing a daily chore or one large weekly one.
-If the weekly chore is chosen a day is to be set on which the chore is to be completed.

CONSEQUENCES:

No free time activity until chore is completed.

PHASE II

THRESHOLD HOUSE RULES

EMPLOYMENT To live here you must have a job and go to it regularly. If you call in sick to work you are too sick to go anywhere else including out that night.

UNEMPLOYMENT If you quit your job you have two weeks to get another. During that 2 weeks you have to look for work daily (at least 3 applications per day). During the time you are unemployed you will have a strict curfew of 10pm on weekdays and midnight on weekends. No exceptions and no overnight passes. If you are unemployed for longer than 2 weeks we will ask DSHS to find another placement for you.

CURFEWS We have an agreement that you can set your own curfews. This is a responsibility as well as a privilege. In order to set your own curfew you need to speak to a staff person, tell them what time you will be home and where you are going. This can be done over the phone but you must speak to a staff person. If you leave a message it doesn't count.

CHORES Chores are done daily. Each household member chooses a night when they are responsible to clean the living room, dining room and kitchen. A list of what needs to be done will be posted on the refrigerator. You are responsible for your things. If you leave your clothes, make-up etc. around the house they will be confiscated and you will be charged 25c for each item. You are responsible to clean up your own dishes and food from the table. The house needs to be kept clean. If it isn't everyone will be put on a curfew for one week. If it stays clean for that week we go back to normal.

PHONE You are allowed to use the phone until midnight on week days and 1am on weekends. If you are talking and someone else gets a phone call wrap up your call so the other person can take their call.

VISITORS Visitors are allowed until midnight on weekdays and 1am on weekends. Please do not have guests in your rooms since you need to respect the privacy of your roommate.

DRUGS AND ALCOHOL Don't do it! This is grounds for termination from the program. We have the right to do periodic UA's. A mandatory drug & alcohol group is held weekly.

HOUSE MEETINGS House meetings are once a week and you must attend them. Each girl will meet once a week with their case worker and a staff member to plan goals.

PRIVACY Do not go into anyone's room unless you are invited. Do not borrow things without permission.

RESPECT Respect your roommates. If you have a problem with someone talk to them about it. If you are too angry or afraid to, ask a staff to help. That's what we're here for.

WEAPONS No weapons are allowed.

OVERNIGHT PASSES If you want to spend the night somewhere you need to get permission and a staff person needs to talk to a responsible adult in the house. You need to leave a number where you can be reached.

RESIDENT CONTRACT

APPENDIX E

Transitional Living Center (TLC)
Iowa Homeless Youth Center (Youth & Shelter Services, Inc.)
1219 Buchanan Street, Des Moines, Iowa 50316
(515) 265-1222

I, _____, will obey the rules of this resident contract which are checked below. I further agree to obey the law, stay chemical-free, keep appointments on time, and cooperate with the Homeless Project Staff, my Probation Officer of Social Worker (if applicable) as part of this contract. I understand that this Resident Contract will also serve as a lease and that I am hereby entering into a landlord-tenant relationship with the Iowa Homeless Youth Center (YSS).

RESIDENCE

_____ 1. I will live at the Transitional Living Center, 1219 Buchanan Street where I will agree to be supervised by Iowa Homeless Youth Center staff and the in-house mentors.

_____ 2. I will enter the TLC starting (Admission Date) _____.

_____ 3. I may remain no longer than 24 months. The planned date of my departure is scheduled for (Date) _____ and I will be given 30 days written notice by TLC Staff before the end of my planned departure. I may request review of the proposed discharge date. Any request for such review must be made not less than 10 calendar days before the end of the residency period. Based on TLC Staff review of the merits of my request, my residency period may be extended but limited to a period not to exceed 24 months from the date of admission to the TLC. If the TLC Staff determines that the discharge date in the notice is too early, the TLC Staff may withdraw the discharge notice and notify me of this action. Notice must be in writing and personally served to me no later than five days before the discharge date in the notice of discharge. Withdrawal of a discharge notice under this clause shall not have any effect upon TLC Staff services of any subsequent discharge notice to me.

_____ 4. I will pay the Iowa Homeless Youth Center $_____ per month rent by the first of the month. (This represents either 30 percent of the individual's monthly adjusted income or 10 percent of the individual's monthly income, whichever is highest.)

_____ 5. I will, by (Date: _____), pay IHYC a damage deposit which will be returned to me if no outstanding bills or damage is found 45 days after my discharge.

_____ 6. I will pay all phone bills and utility bills on time. Payment for these bills will be given directly to the Homeless Project Staff.

_____ 7. I agree to be in the TLC no later than _____ on weekdays and _____ on Friday and Saturday nights. Exceptions may be made for special events with prior approval (24 hours in advance, during office hours) by the staff.

_____ 8. I agree to remain in Polk County and not to travel beyond the County unless I have prior approval (24 hours in advance, during office hours) from the staff.

_____ 9. I will abstain from all drugs and alcohol and will never have chemicals in the TLC unless under a doctors prescription. Medications I am under now include: _____
_____.

_____ 10. I will be responsible for buying and preparing my own food, and will assist with the weekly group meals.

_____ 11. I will share housekeeping duties with my roommates and will keep the TLC clean and organized. This will include weekly laundry, weekly vacuuming, weekly bathroom and bedroom cleaning, and other chores as follows:

_____

_____

_____

_____ 12. Upon departure from the Transitional Living Center I will pay for any and all damage to the TLC and furniture. I will report any damage immediately.

_____ 13. I will treat my roommates in the TLC with courtesy and consideration. I will display a positive attitude toward others and display an orderly and quiet disposition in and around the building.

_____ 14. I will take a shower daily and I will display good personal hygiene.

_____ 15. I will review my budget with staff each month.

_____ 16. I will get approval from TLC staff to have guests over and will work out the details (hours, where, etc.) with staff.

_____ 17. Other: _____

_____

_____

_____

_____

SCHOOL/WORK

_____ 18. I will attend school and all my classes every day; I will do my work and not cause behavioral problems while there, or interfere with the education of others. I will attend school every day unless the staff gives me permission to remain home for reasons of illness. If I am ill I will notify the in-house staff as soon as possible (before 8:00 a.m.). My school hours are: _____.

_____ 19. I will be at work every day and not cause behavioral problems, or interfere with the work of others. I will be at work every day unless staff gives me permission to remain at home for reasons of illness. My place of employment is: _____,
and my hours are: _____.

_____ 20. Other: _____

DRIVING

_____ 21. I will not drive a car or other motorized vehicle.

_____ 22. I will drive a car or other motorized vehicle only when my parent(s), staff or Provation Officer/Social Worker is with me.

_____ 23. I will drive a car or other motorized vehicle only when given permission by my parent(s), Probation Officer/Social Worker or Center staff.

_____ 24. Other: _____.

BANKING

_____ 25. I have $_____ in my checking and/or savings account as of (Date): _____ and I will maintain a checking and/or savings account at _____bank.

_____ 26. I agree to save 50% of my income (after monthly expenses) which should amount to $_____ to be placed in monthly savings.

_____ 27. I will save $_____ before I leave the Transitional Living Center to insure that I have enough for my deposit, first month's rent and needed furniture and supplies when I move to an apartment.

_____ 28. I will develop a detailed monthly budget including all living expenses and I will follow the budget and keep records of bills and expenses.

_____ 29. I will be on time for all meetings including the following: (check which apply):

		TIME	DAY	LOCATION
____	Counseling Sessions			
____	Independent Living Skills Group			
____	AA Meetings			
____	Session with Homeless Staff			
____	Therapy Group			
____	_____			
____	_____			

_____ 30. I will inform the Center Staff and appropriate others (counselor, AA sponsor, etc.) 24 hours in advance if I am unable to attend these meetings.

_____ 31. I will notify the staff immediately when I have a medical emergency, make medical or dental appointments, have police contacts or charges, or any changes in my job or school status.

_____ 32. Other: _____.

OTHER CONDITIONS

_____ 33. I also agree to the following special conditions of my agreement:

_____
_____
_____
_____
_____
_____
_____
_____

This agreement will be in effect from _____ through _____.

_____ CLIENT

_____ HOMELESS PROJECT STAFF

_____ PROBATION OFFICER/SOCIAL WORKER

_____ OTHERS (SPECIFY)

Resident _ _____ VALUE SY: :M Date _____

Staff Member _____ Individual Daily Performance

Caring for Others	Responsibility for Self	Honesty	Forgiveness/ Letting Go	Scores:
- Uses civil language	- Completes daily chores.	- Is honest with self.	- Lets go and does not hold feelings/things against others.	Caring for Others
- Expresses personal feelings w/out attacking or judging	- Participates in ed time according to the guidelines.	- Tells the whole truth about feelings, events (past & present) to others.	- Lets go; does not hold feelings/things against family.	Responsibility for Self
- Listens to others so that others feel heard	- Takes care of self-hygiene and clothing.	- Gets permission before using others' or shelter property.	- Lets go; does not hold feelings/things against self.	Honesty
- Speaks directly to others	- Goes to bed and wakes up on time	- Talks and gets out feelings.	- Recognizes that people do the best they can with what they have at the time.	Fairness
- Makes observations about own behavior and how it effects others.	- Makes positive opportunities out of difficult situations.	- Does own work in Ed. time/ Accurately reports completion of assignments.	- Gives others and self the chance to change.	Forgiveness
- Does not set up others.	- Participates in group activities.	**Fairness**	- Works on resolving conflicts.	Average Score
- Shares observations of other's behaviors w/out insulting him/her.	- Structures and uses free time constructively.	- Compromises (gives a little to get a little).		
- Shows support/gives encouragement when others need it.	- Responds to feedback from others.	- Treats others as s/he would want to be treated.		
- Sets a good example by being a positive role model.	- Works toward resolving issues and reaching goals.	- Accepts the consequences of own actions.		
- Socializes w/out bothering others in smoking area.	- Uses acceptable table manners.	- Accepts differences between/among individuals.		
- Shows respect for other's property and space.				

APPENDIX F - SDVCS

DAILY SUMMARY

DATE:_____

Appendix F-2

NAME: _____
CLIENT #: _____
LEVEL: _____

1. Education time:

2. Recreation time:

3. Peer interactions:

4. Staff interactions:

5. Progress made towards case plan and other considerations:

6. General Impressions and observations (affect, behavioral patterns, attitudes, etc.):

STAFF SIGNATURE A.M./P.M. _____ A.M./P.M _____

r: 10/89

The Value System

DEFINITIONS	PRIVILEGES
Level IV - Leaders	
Resident shows role model behavior and provides positive direction to other residents.	Privileges include those of Level III plus additional privileges to be negotiated $4.50 allowance
Level III - Initiators	
Resident does necessary tasks and lives by program values with minimal staff direction.	May attend staff meeting Late bedtime Walks up to 1 and 1/2 hours Plan own structure time/ rec.time May have friends as visitor Six hour passes with family Radios overnight $3.50 allowance
Level II - Partners	
Residents and staff work together and put equal amounts of energy into the resident's stay.	Shopping helper Special projects Four hour passes with family Store runs up to a half hour Group outings One to one passes with staff Leader of groups Radios during the day $2.50 allowance
Level I - Discoverers	
Resident needs a lot of guidance and support to accomplish tasks and live by program values **OR** the resident is on the 48 hour orientation period.*	Phones Use of recreation equip. Family visitors Walks with staff $1.50 allowance * Structured group outings
Level 0 - Space Takers	
Resident violates major program guide line or has shown no progress on Level 1 for 4 days. Resident may leave program if on Level 0 three times during his/her stay or if he/she remains on Level 0 for more than 48 hours at any one time.	Office phone for "business" or family calls only. Two hour task One page essay

APPENDIX G
IOWA HOMELESS YOUTH CENTER OUTREACH SURVEY

YOUTH SURVEY

ID#_____

DATE_____

YOUTH CHARACTERISTICS

1. 1___Male 2___Female

2. What is your date of birth? _____

3. What is your Race/Ethnic origin (check one)?

1___ American Indian/Alaska Native
2___ Asian or Pacific Islander
3___ Black/Negro not of Hispanic origin
4___ White - not of Hispanic origin
5___ Hispanic

4. What is your current school status (check one)?

1___ Attending school (public or private)
2___ Suspended
3___ Expelled
4___ Dropped out
5___ Graduated from high school
6___ Attending alternative school/home bound program
7___ G.E.D.

5. What is the last grade of school you completed (check one)?

1___ Grade 5 or less
2___ Grade 6
3___ Grade 7
4___ Grade 8
5___ Grade 9
6___ Grade 10
7___ Grade 11
8___ Grade 12 or more

LIVING SITUATION/FAMILY

6. Indicate the living situation in which you spent the most time during the past year (check one).

1___ Home with parent(s) or legal guardian
2___ Relative's home
3___ Friend's home
4___ Foster home
5___ Group home
6___ Correctional Institution
7___ Independent living situation (self or other youth(s) under 19 years)
8___ On the run/street
9___ Other institution (boarding school mental hospital, youth shelter, etc.)
10___ Other adult (19 or older)

What is the family structure of your primary household?

7. Father Figure (check one)

1___ Natural father
2___ Adopted father
3___ Stepfather
4___ Foster father
5___ Other relative(s)
6___ Other adult male
7___ None

8. Mother Figure (check one)

1___ Natural mother
2___ Adopted mother
3___ Stepmother
4___ Foster mother
5___ Other relative(s)
6___ Other adult female
7___ None

Which best describes the type of employment of your parents or step parents in the home in which you have spent most of your time?

9. Father Figure
(Check all that apply)

1___Full time
2___Part time
3___Seasonally employed
4___Unemployed
5___Public Assistance
6___Other
7___No father figure

10. Mother Figure
(Check all that apply)

1___Full time
2___Part time
3___Seasonally employed
4___Unemployed
5___Public Assistance
6___Other
7___No father figure

11. Which best describes the education of your mother or step mother? (Home in which you have spent the most time)

1___Grade school or less
2___Some high school
3___Completed high school
4___Completed high school and received some other training
(some college or trade school)
5___College graduate

12. Which best describes the education of your father or step father? (Home in which you have spent the most time)

1___Grade school or less
2___Some high school
3___Completed high school
4___Completed high school and received some other training (some college or trade school)
5___College graduate

13. What is the occupation of your mother or step mother mentioned above? (please specify)_____

14. What is the occupation of your father or step father mentioned above? (please specify)_____

STREET LIFE

15. Have your ever (answer all that apply):

	Never 1	Once 2	2 - 3 times 3	More than 3 times 4
A. Talked with a child-welfare worker	___	___	___	___
B. Talked with a school counselor	___	___	___	___
C. Talked with a probation officer	___	___	___	___
D. Talked with a mental health counselor	___	___	___	___
E. Talked with a substance abuse counselor	___	___	___	___
F. Talked over running away with a friend	___	___	___	___
G. Talked over running away with an adult	___	___	___	___
H. Called a National or local crisis line	___	___	___	___
I. Been in a foster home	___	___	___	___
J. Been in a residential drug or alcohol treatment program	___	___	___	___
K. Been in juvenile detention	___	___	___	___
L. Been in a residential group home	___	___	___	___
M. Lived with a relative other than your parents	___	___	___	___

16. To support yourself on the streets, have you ever (mark all that apply):

	Never 1	Rarely 2	Occasionally 3	Often 4	Always 5
A. Sold drugs	___	___	___	___	___
B. Panhandled	___	___	___	___	___
C. Got food from dumpsters	___	___	___	___	___
D. Shoplifted	___	___	___	___	___
E. Broke in and took things from a store, house, etc.	___	___	___	___	___
F. Took money or something else from someone by force	___	___	___	___	___
G. Sold sexual favors	___	___	___	___	___
H. Other	___	___	___	___	___

17. While on the street have you ever been (mark all that apply):

	Never	Once	2 - 3 times	More than 3 times
A. Beaten up	___	___	___	___
B. Robbed	___	___	___	___
C. Sexually Assaulted	___	___	___	___
D. Threatened with a weapon	___	___	___	___
E. Assaulted with a weapon	___	___	___	___
F. Propositioned for sexual favors	___	___	___	___
G. Propositioned to break the law (stealing, sell drugs, etc.)	___	___	___	___
H. Hungry 12 hours or more because you could not buy food	___	___	___	___

18. While on the street have you ever <u>seen</u> someone (mark all that apply):

	Never	Once	2 - 3 times	More than 3 times
A. Beaten up	___	___	___	___
B. Robbed	___	___	___	___
C. Sexually Assaulted	___	___	___	___
D. Threatened with a weapon	___	___	___	___
E. Assaulted with a weapon	___	___	___	___
F. Propositioned for sexual favors	___	___	___	___
G. Propositioned to break the law (stealing, sell drugs, etc.)	___	___	___	___
H. Get food from dumpsters	___	___	___	___

19. Has a parent, foster parent, or an adult relative ever (mark all that apply):

	Never	Once	2 - 3 times	More than 3 times
A. Thrown something at you in anger	___	___	___	___
B. Pushed, shoved, or grabbed you in anger	___	___	___	___
C. Slapped you	___	___	___	___
D. Spanked you	___	___	___	___
E. Hit you with something	___	___	___	___
F. Beat you up	___	___	___	___
G. Threatened you with a gun or a knife	___	___	___	___
H. Assaulted you with a gun or a knife	___	___	___	___
I. Made a verbal request to you for sexual activity	___	___	___	___
J. Touched or attempted to touch you sexually	___	___	___	___
K. Engaged in sexual activities with you against your will	___	___	___	___

20. Now we would like to ask how you feel about the financial situation of the <u>family</u> in which you spent most of your time during the past year. If you spent last year in a foster home or a group home, skip to question 21. For each of the following indicate how much you agree or disagree with the statement.

	Strongly Agree 1	Agree 2	Neutral 3	Disagree 4	Strongly Disagree 5
A. My family has enough money to afford the kind of home we would like to have	___	___	___	___	___
B. We have enough money to afford the kinds of clothes we should have	___	___	___	___	___
C. We have enough money to afford the kind of car we need.	___	___	___	___	___
D. We have enough money to afford the kind of medical and dental care we need.	___	___	___	___	___
E. We have enough money to afford the kind of leisure and recreational activities we want to participate in.	___	___	___	___	___

21. How often have you used each of the following substances during the last <u>two months</u>?

	Never 0	Once or Twice 1	Two or Three 2	About Weekly 3	Almost Daily 4
A. Beer	___	___	___	___	___
B. Hard liquor	___	___	___	___	___
C. Marijuana (pot, grass)	___	___	___	___	___
D. Cocaine (coke, Crack)	___	___	___	___	___
E. Opiates (heroin, morphine)	___	___	___	___	___
F. Amphetamines (speed, black cadillacs, white cross, crystal)	___	___	___	___	___
G. Hallucinogens, (LSD, mescaline, peyote acid)	___	___	___	___	___
H. Tranquilizers (librium, valium)	___	___	___	___	___
I. Barbiturates (downers, quaaludes, sopers, reds)	___	___	___	___	___

22. Have you ever injected yourself with drugs? Yes___ No___

23. If you answered "YES" to question 22, how often have you shared needles when shooting drugs? (circle number that applies)

Never	Once or Twice	Two or Three	About Weekly	Almost Daily
0	1	2	3	4

24. When using alcohol or any drug, have you ever had any of the following problems?

	Never 1	Once 2	2 - 3 times 3	More than 3 Times 4
A. Could not remember later what I had done	___	___	___	___
B. Missed school or work	___	___	___	___
C. Used more than I had planned	___	___	___	___
D. Got in an argument	___	___	___	___
E. Got in a fight	___	___	___	___
F. Got fired from work or suspended from school	___	___	___	___
G. Got an OWI	___	___	___	___
H. Arrested for possession, purchase or sale of a controlled substance	___	___	___	___
I. Suffered from severe shaking	___	___	___	___
J. Heard voices when no one was there	___	___	___	___
K. Seen things that weren't there	___	___	___	___
I. Other legal problems (arrests for disorderly conduct, assault, etc.)	___	___	___	___

25. Please indicate whether you agree or disagree with the following statements.

	Agree	Disagree
A. I sometimes feel bothered by how much I use drugs.	___	___
B. My friends think I use drugs excessively	___	___
C. My relatives think I use drugs excessively	___	___
D. I haven't always been able to stop using drugs when I wanted to.	___	___
E. I have gone to a member of my family for help about my use of drugs.	___	___
F. I have lost friendships because of my drug use.	___	___
G. Sometimes after using drugs I have been confused for a period of time	___	___
H. I have been told by a doctor to stop using drugs.	___	___
I. I have sought professional help because of my use of drugs.	___	___

26. Have any of the following relatives ever had problems with alcohol or drugs?

	Yes	No
A. Mother	____	____
B. Father	____	____
C. Brother	____	____
D. Sister	____	____

27. Have you ever been admitted to any of the following because of your use of drugs?

1____Hospital
2____Chemical dependency unit
3____Emergency room
4____Aftercare program

FEELINGS

Please place a checkmark by the statement which describes you most of the time.

28. 1___I do not feel sad.
2___I feel blue or sad.
3___I am blue or sad all of the time and I can't snap out of it.
4___I am so sad or unhappy that I can't stand it.

29. 1___I get as much satisfaction out of things as I used to.
2___I don't enjoy things the way I used to.
3___I don't get real satisfaction out of anything anymore.
4___I am dissatisfied with everything.

30. 1___I am not particularly discouraged about the future.
2___I feel discouraged about the future.
3___I feel I have nothing to look forward to.
4___I feel that the future is hopeless and that things cannot improve.

31. 1___I don't feel disappointed in myself.
2___I am disappointed in myself.
3___I am disgusted with myself.
4___I hate myself.

32. 1___I don't have any thoughts of harming myself.
2___I have thoughts of killing myself but I wouldn't carry them out.
3___I would like to kill myself.
4___I would kill myself if I could.

33. 1___I can sleep as well as usual.
2___I don't sleep as well as I used to.
3___I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
4___I wake up several hours earlier than I used to and cannot get back to sleep.

34. Each of the following statements describe feelings which you may or may not have. Decide how you feel and choose one of the following responses.

	Strongly Disagree 1	Disagree 2	Agree 3	Strongly Agree 4
A. I feel I am a person of worth, at least on an equal basis with others.	___	___	___	___
B. I feel that I have a number of good qualities.	___	___	___	___
C. All in all, I am inclined to feel that I am a failure.	___	___	___	___
D. I am able to do things as well as most other people.	___	___	___	___
E. I feel I do not have much to be proud of.	___	___	___	___
F. I take a positive attitude toward myself.	___	___	___	___
G. On the whole, I am satisfied with myself.	___	___	___	___
H. I wish I could have more respect for myself.	___	___	___	___
I. I certainly feel useless at times.	___	___	___	___
J. At times, I think I am no good at all.	___	___	___	___

35. Has a close friend of yours ever:

	Yes	No
A. Runaway	___	___
B. Sold drugs	___	___
C. Used Drugs	___	___
D. Been suspended from school	___	___
E. Dropped out of school	___	___
F. Shoplifted	___	___
G. Broke in and took things from a house, store, etc.	___	___
H. Took money or something else from someone by force.	___	___
I. Sold sexual favors	___	___
J. Been arrested	___	___
K. Committed suicide	___	___
L. Assaulted someone with a weapon	___	___
M. Been beaten up or injured by a parent or step parent	___	___
N. Been sexually abused	___	___

36. Please indicate the extent to which you agree or disagree with the following statements:

		Agree	Disagree
A.	My parents would help me if I were to get into serious trouble.	___	___
B.	My parents find fault with me even when I don't deserve it.	___	___
C.	My parents really care about me.	___	___
D.	My parents are dissatisfied (unhappy) with the things I do.	___	___
E.	My parents blame me for all their problems.	___	___
F.	I wish my parents would treat me more like other kids' parents treat them.	___	___
G.	I feel that my parents treat me unfairly.	___	___
H.	If someone hits me first I let him/her have it.	___	___
I.	When someone makes a rule I don't like, I want to break it.	___	___
J.	When I get mad, I say nasty things.	___	___
K.	If people annoy me, I tell them what I think of them.	___	___
L.	When someone is bossy, I do the opposite of what he/she asks.	___	___
M.	If I have to use physical violence to defend my rights, I will.	___	___
N.	I haven't done well in school.	___	___
O.	I am not very good at reading.	___	___
P.	I haven't gotten along well with teachers.	___	___
Q.	I have often gotten in trouble at school for arguing, fighting or not following the rules.	___	___
R.	I am not very good at math.	___	___

37. Are you aware of any gangs that exist in the Des Moines area? 1 no___ 2 yes___

38. Have you ever been threatened or harassed by the members of a Des Moines gang?
1 no___ 2 yes, once or twice___ 3 yes, several times___

39. Have you ever been asked to join a gang? 1 no___ 2 yes___

40. Are you presently the member of a Des Moines gang?
1 no ___ IF "NO" SKIP TO QUESTION 45
2 yes___

41. If yes, please indicate the extent to which the following items describe important reasons for belonging to this group?

		Not Important	Some What Important	Important	Very Important
A.	My friends are members	___	___	___	___
B.	I can depend on other members	___	___	___	___
C.	We get high together	___	___	___	___
D.	I feel safer	___	___	___	___
E.	I can make money doing things like selling drugs	___	___	___	___
F.	I like the excitement of fighting with other groups and gangs	___	___	___	___
G.	I take pride in belonging to the group	___	___	___	___
H.	Members care about and help each other	___	___	___	___

42. How long have you been a member?
1___less than six months
2___six months to a year
3___over a year

43. What is the name of your gang?_____

44. Does your gang have chapters in other cities? 1 no___ 2 yes___

45. Have you ever experienced sexual intercourse? Yes___ No____
IF "NO" SKIP TO QUESTION #49

46. About how often have you had sexual intercourse in the past 2 months?

_____

47. When you had intercourse how often did you or your partner use a condom?
1___Never
2___Seldom
3___Almost every time I had sexual intercourse
4___Every time I had sexual intercourse

48. What type of birth control do you or your partners use?
1____None
2____Condom
3____Foam, jelly and/or diaphragm or other barrier method
4____Pill

49. How worried or concerned are you about the possibility of getting AIDS?
1___Very concerned
2___A little concerned
3___Not very concerned
4___Not concerned at all

50. Have you ever runaway from home? ____Yes ___No

If "YES", how many times have you run away? _____

If you are currently away from home without the permission of your parents or guardians and have been gone for 24 hours or more, please answer the following the questions:

51. Which of the following best describes the area where your parents or step parents were living before you left.
1___City of over 100,000
2___City of 50,000 to 100,000
3___Town or small city of 10,000 to 50,000
4___Small town or 2,500 to 10,000
5___Rural non-farm or farm

52. Were you "barred" from home or told to leave?
1___Yes
2___No

53. Counting all the times you have runaway from home, how much time would you say you have spent living on your own?

1___Less than one week
2___2 - 4 weeks
3___1 - 3 months
4___4 - 6 months
5___7 - 12 months
6___12 - 18 months
7___Over 1 1/2 years

54. How many days have you been away from your legal residence this time?

1___1 day
2___2 - 5 days
3___6 - 10 days
4___11 - 20 days
5___21 - 50 days
6___over 50 days

55. The living situation you left is:

1___In Des Moines or a suburb of Des Moines
2___Elsewhere in Iowa
3___In a different state in the Midwest
4___Outside the Midwest

56. How many different cities have you stayed in overnight since you have been on the streets, counting all the times you have run away in the past year.

_____

57. What were your reasons for running away? (Mark all that apply)

	Very Important	Important	Some What Important	Not at all Important
A. Parents too strict	___	___	___	___
B. Parents physically abusive	___	___	___	___
C. Parents or other adult sexually abusive	___	___	___	___
D. Violence in home	___	___	___	___
E. Parent mentally ill	___	___	___	___
F. Parent did not care about me	___	___	___	___
G. In trouble at home and afraid to return	___	___	___	___
H. Trouble at school	___	___	___	___
I. Not passing at school	___	___	___	___
J. Trouble with friends	___	___	___	___
K. Trouble with legal authorities	___	___	___	___
L. Looking for excitement	___	___	___	___
M. Went with a friend	___	___	___	___
N. Kicked out or barred from home	___	___	___	___

APPENDIX H
EXCERPTS FROM POLICY & PROCEDURES MANUALS

HUMAN IMMUNODEFICIENCY VIRUS (HIV) POLICY

The Bridge, Inc. (Bridge Over Troubled Waters, hereafter referred to as Bridge) was founded in 1970 to "do whatever may be necessary or desirable in assisting youth who are on the streets with no one to comfort them to achieve a place in society as normal and useful citizens". Considering the onset of AIDS and Human Immunodeficiency Virus (HIV) in the street population, Bridge must respond to this crisis in a thorough and thoughtful manner.

In order to fulfill this goal, the following policies have been established:

1) Bridge recognizes its obligation to educate all clients about AIDS, with a particular emphasis on responding to youth engaged in high-risk behaviors such as IV drug use and/or prostitution.

2) All staff, volunteers, and clients are considered to be seropositive for HIV. Infection control procedures established by the Department of Public Health (see Appendices A, B, and C) are to be followed in all cases.

3) All Bridge services are available to clients regardless of their HIV status, unless they are too ill and in need of a more appropriate medical treatment setting. For these clients Bridge will act as an advocate for them to receive appropriate services.

4) Information about any client's HIV status is to be handled with extreme confidentiality. Bridge has established a process to ensure that the only staff members who are informed about a client's HIV status are those who have a need-to-know based upon the best interests of that particular client.

The following are the procedures for the implementation of these policies. Any questions should be directed to the clinical coordinator.

December 1987

I. NEED-TO-KNOW AND CONFIDENTIALITY

Each component of Bridge has been assigned to an administrator who is responsible for ensuring client confidentiality. Staff members in these components are responsible for informing the administrator, not their component coordinator, of any clients who are seropositive and/or diagnosed as having ARC or AIDS. Staff members may also inform the nurse practitioner if medical consultation is necessary. In order to preserve client confidentiality, no other staff members should be told of a client's HIV status.

The administrator, in turn, is responsible for the following:

1) To determine if any additional staff members need to be informed of a client's HIV status, and to share appropriate information with them.

2) To evaluate what additional supports staff may need to most effectively serve these clients. This support may include individual supervision around counter-transferential issues, individual consultation with the clinical consultant, reading materials and/or additional training.

3) To develop appropriate statistical data to be reported to the Executive Director in order that Bridge may project future trends and needs.

4) To identify gaps in services for these clients in order that Bridge may effectively address these needs through program development and/or advocacy within the medical and social service community.

5) To ensure that confidentiality is maintained throughout all client record-keeping.

Administrators have been assigned to components as follows:

Clinical Coordinator	Family Life Coordinator	Residential Coordinator
Counseling	Family Life Center	Independent Living-Phase I
Dental Clinic	Single Parent Residence	Co-op Apartments - Phase II
Ed/Voc		
Hotlines		
In-Service Trainees		
Medical Van		
Runaway		
Streetwork		

Bridge staff members are expected to handle all information regarding client's HIV status with the highest standards of professionalism and respect for our client's privacy. To insure that only staff with a need-to-know have access to this information, a client's HIV status may not be discussed in peer consultation, staff or team meetings. As necessary, administrators will arrange for individual clinical consultation. Violation of this or any other confidentiality policy may be grounds for termination of employment.

II. RECORD-KEEPING

Information about client's HIV status may only be recorded in the client's medical record. There should be no reference to it in any other file. Records in the counseling and Family Life components must be coded with a phrase to be determined by the clinical coordinator. This code phrase will be changed periodically. Records in the Ed/Voc, Residential and Streetwork components should have no information re: HIV.

Information about a client's HIV status may not be disclosed to another agency without the informed written consent of the client. A separate release of information must be signed for HIV information. It cannot be disclosed under a more general release for medical records, physical exam, psychosocial evaluation, etc. If this additional information is also being disclosed, two release forms are necessary. Any release form making reference to a client's HIV status is to be filed in the client's medical record, regardless of what component originated the release form.

Efforts to educate clients about HIV and AIDS must be documented in counseling files. However, this must not be recorded in the progress notes, or any other part of the permanent record (i.e. intake, treatment plan, etc.). Rather, a separate form is available that client's must sign to document AIDS education. In the event that files are released to another agency, this form is to be removed from the client's file.

III. RESIDENTIAL PLACEMENT

Beginning January 1, 1988, all clients entering Bridge services are to be informed of the possibility that they may be in treatment with persons who are HIV positive and/or have ARC or AIDS. This is to be done through a letter to them from the Executive Director. The letter also informs clients that they cannot contract HIV through casual contact including sharing living space with others, and that they may review Bridge policies on HIV if they wish. The referring counselor must have client's sign a receipt for the letter.

Bridge residential services are available to clients who have tested seropositive for HIV and/or have been diagnosed as having ARC or AIDS if they are able to meet the same expectations as other clients and the following conditions are met:

1) They have medical clearance from their primary physician indicating that they are physically able to reside at Bridge. It is the responsibility of the referring counselor to brief the physician on the program, including both expectations of clients and program limitations.

2) The client agrees to following through with all medical appointments, and understands that s/he may be terminated from the residential program for failure to do so.

In the event that the primary physician does not give medical clearance for a client to enter a Bridge residential program, the referring counselor will locate an appropriate alternative placement, with assistance from the Department of Public Health if necessary.

IV. DENTAL

All dental volunteers should be aware of the symptoms of HIV infection, with a specific emphasis on the clinical oral manifestations of the disease. The dental coordinator is responsible for ensuring that the dental volunteers are appropriately trained on HIV infection.

If a dental volunteer suspects HIV infection in a client, s/he should inform the dental coordinator, not the client. The coordinator, in turn, is responsible for ensuring that follow-up care is arranged through the medical component at Bridge.

Dental records should not contain any reference to a client's HIV status. Should clients disclose their HIV status to a dental volunteer, the coordinator should be informed verbally. The coordinator is responsible for ensuring both that confidentiality is maintained and that appropriate dental care is provided. Under no circumstances should a client's HIV status be discussed with any other volunteers, staff members or clients.

V. MEDICAL

All medical volunteers should be aware of the signs and symptoms of HIV (Human Immunodeficiency Virus) infection, particularly in relation to a street lifestyle. The Medical Coordinator is responsible for ensuring that the medical volunteers are appropriately trained in regard to HIV infection.

If a medical volunteer suspects HIV infection in a client, s/he should inform the medical coordinator, not the client. Since many other diseases manifest themselves with similar signs and symptoms in this particular population, it is imperative that medical follow-up is initiated. The Medical Coordinator, is then, in turn, responsible for ensuring that follow-up care (counseling, antibody testing - if requested, etc.) is arranged through the medical component at Bridge.

Medical records should not contain any reference to a client's HIV status. The client's chief complaint on the medical record may read "HIV Related Concerns", but specific terms such as "AIDS", "ARC" or "HIV$^+$" are not to appear on the medical van records. The coordinator is responsible for ensuring both that confidentiality is maintained and that appropriate medical care and follow-up is provided. UNDER NO CIRCUMSTANCES should a client's HIV status be discussed with other volunteers, staff members, or clients. Failure to observe this confidentiality will result in immediate termination of the volunteer with this agency.

THE BRIDGE, INC.

POLICY AND PROTOCOL ON HIV TESTING

Bridge recognizes that the decision to be tested for HIV is an extremely sensitive issue for our clients. Our clinical experience has shown that a positive test result invariably precipitates a severe depression that is typically accompanied by suicidal ideation and/or suicidal attempts. For clients who are active substance abusers, Bridge has always seen an escalation of substance abuse immediately after a seropositive test result. Conversely, Bridge has seen that clients engaging in high-risk behavior who test negative for HIV become more entrenched in their denial of their risk. Given that at present there is no medical treatment for asymptomatic HIV, Bridge's policy is to advocate testing only for clients who are symptomatic or those considering pregnancy. These clients are referred to the Nurse Practitioner who performs a physical exam, and, in conjunction with the counselor, provides pre-and post-test counseling, referral, advocacy, and support.

Asymptomatic clients requesting HIV testing are seen in individual counseling. Counselors work with them to explore their reasons for desiring a test, their level of knowledge of the HIV antibody test, the impact both a positive or a negative test would have on their lives, to whom and how they would choose to disclose the tests results, etc. This process typically takes at least three counseling sessions, and clients are encouraged to reflect on these issues between visits. During this time, counselors are assessing clinical issues that will impact on clients' responses to testing including clients' substance abuse, depression, isolation, impulsivity, suicidality, quality of social network, quality of family relationships, etc. Throughout this process, counselors continually emphasize the need to practice risk-reduction regardless of the outcome of the test.

When clients are ready for testing, the counselor consults with the Clinical Director and the Nurse Practitioner regarding the most appropriate referral. Most frequently, clients are referred to Project Trust or to the Fenway Community Health Center. Bridge counselors accompany clients to all test site visits to provide client advocacy and support.

Post-test counseling is a continuation of the pre-test dialogue with an emphasis on mobilizing support resources previously identified, support group referrals, etc. Clients with a negative result are encouraged to retest in three to six months. Clients with a positive result are referred to the Nurse Practitioner who will respond to clients' concerns about their health, and coordinate their medical care. Again, post-test counseling emphasizes the need for continued risk reduction.

The Bridge, Inc.
HIV Symptomatic Clients

Total	1986	1987	1988	Total
	3	5	10	18
Race				
White	3	5	8	16
Black	-	-	1	1
Hispanic	-	-	1	1
Sex				
Male	2	5	8	15
Female	1	-	2	3
High-risk Behavior				
IVDU (only)	-	1	-	1
Prostitution (only)	-	-	3	3
IVDU/Prostitution	3	4	6	13
Sexual Partner of IVDU	-	-	1	1

Age
Total Mean: 22.2
1986/1987 Mean: 22.75
1988 Mean: 21.6

Note:

These statistics include only those youth who have symptomatic HIV confirmed by a medical service provider. They do not include:

1. Asymptomatic HIV
2. Clients with HIV-like symptoms who refuse to test.
3. Clients who report symptomatic HIV, but we cannot confirm it through service providers
4. Clients about whom we hear rumors of HIV-related illness

1986-1988 (In-place)

Policies
Staff Training (downtown)
Educational Resources - brochure, video, letter, etc.
Individual counseling and education
Infection control procedures and supplies
Survey
Individual clinical consultation
Nurse Clinic
Testing/Treatment Resources
Informational resources - HIV record, mailing lists, etc.
Documentation - statistics
Staff support group
Public/professional educational and advocacy

1989
Coordinator subcommittee for program development
Regularly scheduled workshops - FLC, Voc/Ed, Residential
Staff Training - Residential
Personnel Policy
Counselling protocol re: testing
Produce Bridge video
Finalize goals and objectives

1990
Off-site support group for clients
Expand nurse clinic
Hospital linkage
Expand individual consultation
Repeat survey
Revise brochure, letter
Evaluate need for separate vs. mainstreamed residential program
Expand staff-support group

1991
Evaluate case management programming needs
Implement residential programming changes

STRATEGIC PLAN

Mission Statement

Seattle Youth and Community Services (SYCS) exists to provide programs which improve the quality of life and promote healthy maturation of Seattle's abandoned, runaway and exploited youth. SYCS further provides prevention services to keep young people from entering into this population.

Seattle Youth and Community Services works with young people and their families to help youth mature and stabilize. Programs utilize all available resources, including the family and the potential for effective family relationships. SYCS programs are rooted in the belief that young people must become aware of their choices, make them, and accept responsibility for their lives. To this end they help youth and families learn to help themselves.

Philosophy

SYCS believes that through a variety of life circumstances children may learn dysfunctional and maladaptive ways of relating to the world around them. At times this manifests in problems in the family , at other times in running away. Some of these youth end up on the streets and become further trapped in destructive lifestyles. We believe that these youth are people in trouble, rather than inherently troubled people. Our programs are dedicated to serving them and, when possible, their families.

Seattle Youth and Community Services is built on beliefs and practices which promote the human potential for growth, individuality, self-direction and ultimately independence. Children, adolescents and young adults can learn to take responsibility for their own lives, in contrast to feeling dependent on others. The goal for clients is for each one to work and live effectively, within the framework of his or her current life phase, and to be prepared for their future role as an adult.

Considering the individual's unique abilities, unique situation, and changing needs, SYCS holds that young people's lives are most satisfying when:

...a person enjoys a sense of self-identity and self-esteem.

...a person is in control of his or her own behavior and life, as much as possible

....a person is living in an environment which is safe, provides nurturing, and develops their capacity for Independence.

...a person is challenged.

...a person is growing through learning and new experiences.

...a person learns to solve problems commensurate with his or her ability.

...a person has choices among positive options about his or her future.

...A person takes responsibility for their life.

As chaos is removed from a young person's life; as social, emotional, educational, and physical needs are met; more healthy maturation occurs. This process will enable the young person to more fully realize their potential.

Scope

SYCS works with young people in the greater Seattle/King County area whose ages range from late childhood to young adulthood; most are adolescents. SYCS also works with the infants and children of these adolescents. A holistic treatment approach allows for all significant aspects of the client's needs to be addressed.

Programs are community-based and voluntary. Within a framework of available resources, SYCS provides services to help youth make a successful transition from adolescence to adulthood.

SYCS relies heavily on a vigorous outreach program which includes prevention, education and intervention services. In addition, it provides evaluation services, case work and counseling, day programs, emergency shelter, transition programs and long-term foster care.

Families and youth differ significantly in the nature of their problems and the availability of personal, financial, social and community resources. Therefore, SYCS activities reflect a highly individualized program which stresses the cross-cultural differences among the clients it services. Based upon an assessment of the child and the family, programs attempt to strengthen the family's capacity to be a resource. In all cases, they attempt to help the youth come to terms with her or his family situation.

SYCS is prepared to evaluate and adapt its services to be responsive to shifting characteristics and needs of the

youth in trouble. A planning process ensures that clients and employees have a voice in the formulation of the organization's plans, services and articulation of its values.

A major purpose of SYCS is to reduce the frequency of inter- or multi-generational patterns of personal and family crises, abuse, maladaptation and poor functioning. Toward this end, it extends its involvement to include:

...participation in national efforts to better understand the forces that perpetuate inter-generational problems;

...developing experimental, innovative programs that may become models worthy of replication;

...making research a portion of its operating, functional responsibility;

disseminating information about this population, SYCS programs, and the results of studies or research.

SYCS is a not-for-profit organization. Its funds come from multiple sources; for example, contracts with federal, state, and local governmental agencies the United Way of King county and contributions from individual and organizational donors.

SYCS relies heavily on the competence and sensitivity of its employees. Its human resources policies enhance the ability of employees to grow and to work effectively with this population and each other. These policies incorporate the following beliefs:

a. That staff support and involvement is an integral part of the development of SYCS plans, policies, procedures and services.

b. Staff should be encouraged to advance whether at SYCS, or into leadership positions in other agencies.

Policies promote the professional growth and development of employees and strengthen the SYCS capacity to become more effective.
1988

SYCS

SEATTLE YOUTH AND COMMUNITY SERVICES

1020 Virginia Street Seattle, Washington 98101 (206) 622-3187

CLIENT RIGHTS AND RESPONSIBILITIES

CLIENT RIGHTS

Confidentiality: The right to be protected against the invasion of privacy and confidentiality. We will not share information with anyone without written consent from you unless we are ordered to do so by the court. In order to give you the best possible services we do discuss information at staff consultation meetings. We are also required by law to allow files to be reviewed by funding sources for auditing purposes.

There are two situations in which we are required by law to report confidential information to the authorities:

1. When a person will potentially harm him/herself or others.
2. In cases of physical and/or sexual abuse or neglect.

Services: You have the right:

1. To be treated with dignity
2. To participate in the development of your counseling/casework plan
3. To be provided with service which is in your best interest, responsive to your needs, and in accordance with quality-of-care standards
4. To request that the agency review your services if you are not satisfied
5. To review your file with your counselor provided information confidential to others is not reviewed in the process.

Grievance/Complaint Procedure: If you feel you have been discriminated against in any way or that you have been treated unfairly you have the right to follow the agency grievance procedure. You are entitled to a fair and impartial hearing of complaints regarding these rights and agency decisions affecting your welfare or status as a client. **GIVE YOUTH A COPY OF THE GRIEVANCE PROCEDURE. Explain the steps to them.**

CLIENT EXPECTATIONS

You are expected:

1. To comply with program rules and guidelines
2. To respect all other persons
3. To respect the property of the agency and of others

I have read and understand the statement of Clients Rights and Responsibilities and hereby consent to participate in services provided by Seattle Youth and Community Services. I have also been given a copy of the Client Grievance Procedures.

_____ _____

Client's Signature Date

_____ _____

Counselor's Signature Date

11/89

SEATTLE YOUTH AND COMMUNITY SERVICES

Grievance Procedures for Agency Clients

I. Introduction

This document explains SYCS grievance procedures for clients. It is the goal of SYCS to provide quality services to children, youth and families. SYCS encourages our clients to take a critical look at services provided and we appreciate and value any feedback.

II. Definition

A grievance is a complaint by a client based on alleged unfair treatment by an agency staff member.

Client should, to the best of their ability, document (in writing) the events that created the grievance.

It is the responsibility of SYCS Clinical Director to help clients read, understand and apply this procedure.

III. Procedure

In the event that a client is dissatisfied with services, we ask that they attempt to resolve their grievance in the following manner:

1. Client talks directly to the person or persons they have the grievance with.

2. If it is not resolved, then involve a third person as a mediator. That third person should be the supervisor of the employee that the grievance is with.

3. If it is still not resolved, present the issue to the Clinical Director.

4. If it is still not resolved, present the issue to the Executive Director.

5. If the grievance is still unresolved, the client should contact the chair of the Program Committee of the SYCS Board of Directors.

6. The Program Committee shall investigate the grievance and shall mediate a resolution. If the resolution is unacceptable to any party, the decision may be appealed to the full board.

7. The grievance will be kept on file with the Program Committee for one year.

SYCS

SEATTLE YOUTH AND COMMUNITY SERVICES

1020 Virginia Street Seattle, Washington 98101 (206) 622-3187

SEATTLE YOUTH AND COMMUNITY SERVICES
SUICIDE PRECAUTION AND POLICY

Adolescents who express suicidal ideation should always be taken seriously. If a youth in the program appears suicidal (expresses thoughts, self-destructive actions, etc.) they must be monitored closely. In general if the youth appears serious about suicide, professional help should be sought immediately. The following guidelines should be used to differentiate between youth who need immediate professional attention and those situations that may be handled at The Shelter.

Need for Immediate Professional Help:

(Depending on the situation call 911 or the Mental Health Professional at Harborview 344-4013)

The attempt, gesture or plan is highly lethal.

The youth is extremely agitated or out of control.

The youth is unreceptive to intervention attempts.

May be Handled at The Shelter

The gesture or plan is not very lethal.

The youth seems to have some control of their actions.

The youth is receptive to intervention attempts.

The following precautions should be taken with youth when intervention is done at The Shelter.:

A. Staff should be in eyesight at all times of such youth and during sleeping hours bed checks need to be done every 15 minutes.

B. A suicide contract should be done with the youth, signed and dated and placed in their file.

C. The youth should be isolated from the other young people in the program until the crisis has passed.

D. The environment should be suicide proofed, potential weapons, sharp objects, etc removed from the immediate environed.

E. The Program Manager should be notified immediately (if unavailable, the Clinical Director or Executive Director) and an incident report done.

In the unlikely event a youth in the program makes a suicide attempt the following procedures should be followed:

A. Find out what method they have used, have a coworker or whoever is available call 911 immediately.

B. If the youth has taken drugs:

1. Find out:

a. The name of the drug(s)
b. How much they have taken
c. What other drug(s)/alcohol they have taken in conjunction
d. How long ago food was consumed
e. Their age, sex, height, and weight
f. Any illness

2. Call Poison Control with the above information.

a. If Poison Control says it is a potentially lethal dose, call 911 immediately.

b. If Poison Control says it is not a potentially lethal dose, proceed according to the guidelines presented in "Suicide Counseling."

c. <u>Do not</u> share with the caller the Information that Poison Control gives you.

If a crisis call is received by a youth who is in the process of attempting suicide:

I. Find out their name, location, and phone number.

   A. If they give you their name but not location or phone number, attempt to find their location and phone number by looking in the phone directory.

   B. If they give you their name and phone number but not their location, have a co-worker or whoever is available call the operator, explain the situation, and have the operator look up the location in the reverse directory.

   C. If they will not give you their name, location, or phone number, ask a co-worker or whoever is available to call the operator, tell them a suicide is in progress, and to have the call traced as quickly as possible.

<u>Do Not Answer the Other Phone Lines While on a Suicide Call!</u> If you should and you get two suicide calls at once (this has happened!), tell the second caller that you are also on another line and you would like their number so you can call a co-worker to call them back. Make sure that someone calls them back as soon as possible!

SEATTLE YOUTH & COMMUNITY SERVICES INTAKE FORM

Client Name: _____Date of Birth:_____

Client Address at Intake:_____Date:_____

LEGAL GUARDIAN:

Name:_____Address:_____

Relationship:_____Telephone:_____

DEMOGRAPHIC INFORMATION:

1) Sex: ____Male ____Female 2) Age: ____

3) Race:
1 ____White
2 ____Black
3 ____Hispanic
4 ____American Indian
5 ____Asian-American
6 ____Other
9 ____Unknown

4) Residence at time of intake:
11 ____Parent's home
12 ____Other relative
13 ____Foster care
14 ____Group/res. care
15 ____Detention
16 ____Institution
17 ____Spouse
18 ____Friend(s)
19 ____Alone (Independent living)
20 ____No fixed
21 ____Other:_____
99 ____Unknown

5) Time on streets at intake:
1 ____None
2 ____1-7 days
3 ____8-30 days
4 ____1-3 months
5 ____4-8 months
6 ____9-12 months
7 ____More than 12 months
9 ____Unknown

6) Total time on streets:
1 ____None
2 ____1-7 days
3 ____8-30 days
4 ____1-3 months
5 ____4-8 months
6 ____9-12 months
7 ____More than 12 months
9 ____Unknown

7) Educational Status at intake:
1 ____High school graduate
2 ____In school (Grade_____)
3 ____Alt/GED Program
4 ____Drop out/suspended
5 ____Other (Specify)_____

8) Last school attended:
(Name)_____
(Date last attended)_____

8) Employment status at intake:
1 ____Full time (Employer)_____
2 ____Part time (Employer)_____
3 ____Sporadic or seasonal
4 ____Vocational training
5 ____None

9) Prior full time employment?
1 ____No
2 ____Yes
If yes: Employer _____Length in mo. _____
Employer _____Length in mo. _____

10) Prior part time employement?
1 ____No
2 ____Yes
If yes: Employer _____Length in mo. _____
Employer _____Length in mo. _____

11) Primary referral source:
1 ____Project staff
2 ____Shelter staff
3 ____Orion staff
4 ____DSHS staff
5 ____Youth service agency
6 ____Juvenile court
7 ____Mental health center
8 ____Other:_____

FAMILY SETTING/HISTORY

1) Marital status of biological parents
1 ____Married
2 ____Separated or divorced
9 ____Unknown

2) Adults in family household at time of intake
1 ____Both biological parents
2 ____Mother alone or with others
3 ____Father alone or with others
4 ____Adult relative(s)
5 ____Non-related adults
6 ____No adults
9 ____Unknown

3) Length of time client out of family household
1 ____Currently in household
2 ____Less than 6 months
3 ____6-12 months
4 ____13-24 months
5 ____25-48 months
6 ____More than 48 months
9 ____Unknown

4) Indicate frequency of contact and nature of relationship between client and family members (Frequency = daily, weekly, monthly, less than monthly, or no contact. Nature = excellent, good, fair, poor, no contact).

		Frequency	Nature
1	Mother	_____	_____
2	Step mother	_____	_____
3	Father	_____	_____
4	Step father	_____	_____
5	Siblings	_____	_____

ABUSE HISTORY

1) Was client ever a victim of sexual abuse?
1 ____Yes
2 ____No
9 ____Unknown
If Yes: Abuse inflicted by (mark all relevant):
1 ____Father
2 ____Stepfather
3 ____Mother
4 ____Stepmother
5 ____Other male
6 ____Other female
9 ____Unknown

If Yes: Approximate age of first abuse. _____Yrs._____Mo.

If Yes: Length of abuse. _____Yrs. _____Mo.

If Yes: Was abuse reported to CPS?
1 ____Yes. Specify outcome. _____
_____
2 ____No
9 ____Unknown

2) Was client ever a victim of physical abuse?
1 ____Yes
2 ____No
3 ____Unknown
If Yes: Abuse inflicted by (mark all relevant):
1 ____Father
2 ____Stepfather
3 ____Mother
4 ____Stepmother
5 ____Other male
6 ____Other female
9 ____Unknown

If Yes: Approximate age of first abuse. _____Yrs._____Mo.

If Yes: Length of abuse. _____Yrs. _____Mo.

If Yes: Was abuse reported to CPS?
1 ____Yes. Specify outcome. _____
_____
2 ____No
9 ____Unknown

3) Was client evera a victim of neglect?
1 ____Yes
2 ____No
9 ____Unknown
If Yes: Neglected by whom (mark all relevant)
1 ____Father
2 ____Stepfather
3 ____Mother
4 ____Stepmother
5 ____Other male
6 ____Other female
9 ____Unknown
If Yes: Approximate age of first neglect. _____Yrs. _____Mo.

If Yes: Length of neglect. _____Yrs. _____Mo.

If Yes: Was neglect reported to CPS?
1 ____Yes. Specify outcome._____

SUBSTANCE ABUSE

HAS USED	TYPE	IS USING	FREQUENCY
_____	Alcohol	_____	_____
_____	Marijuana	_____	_____
_____	Cocaine	_____	_____
_____	Heroin	_____	_____
_____	Crystal	_____	_____
_____	Amphetamines	_____	_____
_____	MDA	_____	_____
_____	Acid	_____	_____
_____	Mushrooms	_____	_____
_____	Other_____	_____	_____

*D = Daily; W = At least weekly; M = At least monthly; U = Using, but frequency unknown.

2) Has client received drug/alcohol treatment?
1 ____Yes
2 ____No
3 ____Unknown

If Yes: What type(s) of treatment? (Mark all relevant)
1 ____Counseling
2 ____Outpatient
3 ____Fellowship (AA or NA)
4 ____Inpatient
5 ____Residential
9 ____Unknown

HEALTH

1) Is client suffering any major health problems or physical disabilite
(Specify:) _____
_____
_____

2) Is client currently pregnant?
1 ____Yes
2 ____No

3) Has client given birth?
1 ____Yes
2 ____No

If Yes: Number of children. _____Boys ____Girls

If Yes: Status of children. (Specify with whom child(ren) lives an
means of support.
Child 1 _____
Child 2 _____
If Yes: Does client expect child to live with him/her during progra
involvement?
1 ____Yes
2 ____No
9 ____Unknown

4) Has youth had any sexually transmitted diseases?
1 ____Yes
2 ____No
9 ____Unknown

If Yes: What type(s) of diseases?
_____
_____
_____

MENTAL HEALTH

1) Has youth received counseling?
1 ____Yes
2 ____No
9 ____Unknown

If Yes: Identify type of counseling or counseling provider.
1 ____School counselor/psychologist
2 ____Probation/parole
3 ____Outpatient treatment
4 ____Inpatient treatment
5 ____Outreach or support counseling
6 ____Sexual/physical abuse treatment
7 ____Other: Specify _____

2) Has youth ever been diagnosed?
1 ____Schizophrenic
2 ____Depressive
3 ____Manic Depressive (Bipolar)
4 ____Other: Specify _____

3) Has youth ever attempted suicide?
1 ____Yes
2 ____No
9 ____Unknown

If Yes: When was the last suicide attempt? _____Yr. _____Mo.

If Yes: How did youth attempt suicide?
_____
_____

4) Is youth currently suicidal?
1 ____Yes
2 ____No
9 ____Unknown

5) Current assessment of youth's mental and emotional health.
_____
_____
_____

RUNAWAY HISTORY

1) Does youth have a history of runaway behavior?
   1 ____Yes
   2 ____No
   9 ____Unknown

   If Yes: Estimate total number of runaways. _____ Runs

   If Yes: Age at first runaway. _____ Years old.

   If Yes: What precipitated the first runaway occurrence:
   _____
   _____

2) Is youth considered a risk to run from the program?
   1 ____High risk to run
   2 ____Medium risk to run
   3 ____Low risk to run
   4 ____No risk to run
   9 ____Unknown

PLACEMENT HISTORY

1) Has youth ever been placed out of home?
   1 ____Yes
   2 ____No
   9 ____Unknown

   If Yes: Identify all forms of placement by number of placements.
   1 _____Receiving home (number)
   2 _____Foster home (number)
   3 _____Relative home (number)
   4 _____Institution (number)
   5 _____Group/residential home (number)
   6 _____Hospital (number)
   7 _____Emergency/shelter home (number)
   8 _____Other:_____

   If Yes: Age at first out of home placement? _____Years old.

   If Yes: Reason for first out of home placement.
   _____
   _____

   If Yes: Total time in out of home placement? _____Yrs. _____Mo.

2) Is youth currently in DSHS placement?
   1 ____Yes: Specify _____
   2 ____No

SEXUALITY

1) Is youth:
   1 ____Heterosexual identified
   2 ____Gay/lesbian identified
   3 ____Bisexual identified
   4 ____Non-identified
   9 ____Unknown

2) First sexual experience:
   a. Approximate age. _____Years old.

   b. Abusive situation?
      1 ____Yes: With whom?_____
      2 ____No
      9 ____Unknown

PROSTITUTION INVOLVEMENT

1) Is, or has, youth ever been involved in prostitution?
   1 ____Yes, currently involved
   2 ____Yes, involved in the past
   3 ____Not involved (Go to next section)
   9 ____Unknown (Go to next section)

2) Length of involvement in prostitution.
   1 ____1 - 30 days
   2 ____1 - 3 months
   3 ____4 - 8 months
   4 ____9 - 12 months
   5 ____More than one year
   6 ____Involved, length unknown

3) Frequency of prostitution involvement.
   1 ____Frequent (Once a week or more)
   2 ____Occasional (1 - 3 times a month)
   3 ____Rare (Less than once a month)
   9 ____Unknown

4) Has youth ever been involved with a pimp?
   1 ____Yes, currently involved
   2 ____Yes, but not currently
   3 ____No
   9 ____Unknown

OFFENSE HISTORY

1) Does youth have a juvenile offense record?
   1 ____Yes
   2 ____No
   9 ____Unknown

   If Yes: Identify adjudicated or diverted offenses.
   _____
   _____
   _____

PRESENTING PROBLEMS

Identify youth's presenting problems.

11 ____Suicidal	25 ____Sex offending behavior
12 ____Short term placement	26 ____Prostitution
13 ____Long term placement	27 ____Street involvement
14 ____Drug abuse	28 ____Pregnancy
15 ____Alcohol abuse	29 ____Sexual identity
16 ____Runaway behavior	30 ____Personal/peer relationships
17 ____School problems	31 ____Parent alcohol/drug abuse
18 ____Family conflict	32 ____Adolescent adjustment
19 ____Needs employment	33 ____Depression
20 ____Physical abuse	34 ____Neglect
21 ____Sexualabuse	35 ____Emotionally disturbed
22 ____Incest	36 ____Developmentally disabled
23 ____Rape	37 ____Health _____
24 ____Child(ren)	38 ____Other:_____

Summarize clinical assessment of primary needs. _____
_____
_____
_____

SERVICE ASSESSMENT

Mark all services you believe youth needs in column one; in column two identify services for which youth has indicatd a desire or want.

SERVICE	NEEDS	WANTS
Short term shelter		
Foster care		
Group/residential care		
Independent living		
Medical care		
Dental care		
Education		
Vocational training		
Substance abuse treatment		
Financial assistance		
Legal services		
Parenting training		
Anger management		
Skills development		
Other _____		

_____

SERVICE PROVIDERS

List all other service providers currently working with youth.

1 ____Juvenile Probation _____
2 ____Juvenile Parole_____
3 ____School _____
4 ____Mental Health _____
5 ____Health Care_____
6 ____Youth Service Bureau _____
7 ____DSHS _____
8 ____Outreach Counseling (Orion, etc.)_____
9 ____Substance Abuse _____
10 ____Other:_____
11 ____Other:_____

YOUTHCARE

INFECTIOUS DISEASE CONTROL PROCEDURES FOR NON-AIRBORNE DISEASES INCLUDING AIDS AND HEPATITIS B

INTRODUCTION

The purpose of these procedures is to instruct staff who are involved in child care and direct service with YouthCare clients of guidelines for preventing the spread of the AIDS virus (HTLV-III/LAV) and Hepatitis B. These viruses are both transmitted through bodily fluids and are blood-borne viruses. The AIDS virus has been cultured from both saliva and tears, although there is no evidence that it is transmitted through these secretions. Control procedures are directed at the exchange of bodily fluids. Both hepatitis and AIDS are primarily transmitted through sexual contact and the sharing of needles. There is no evidence that these are airborne viruses, and with standard precautions there is little risk of infection to staff. Because both viruses are not always apparent these guidelines should be used in providing care to ALL clients.

HAND-WASHING

Thorough hand-washing with soap and hot water should occur before and after physical care of infected clients. Handwashing should be done for at least sixty seconds under hot running water.

GLOVES

Disposable gloves should be available at all program sites. Gloves should be worn for any contact that exposes staff to blood or bodily secretions. This includes any direct blood contact such as cuts, sores, bloody nose, etc. Gloves should also be worn when cleaning up if a client has been incontinent or vomiting. Hands should be washed after removal of gloves. Gloves are not necessary for general care or casual contact.

SOILING

General household cleaners are adequate for cleanup of soiled materials. A disinfectant of bleach mixed with one part bleach to nine parts water should be additionally used for clean up of any bodily fluids. This solution should be applied after washing with soap and water. This solution should be used routinely in toilet bowls, bathtubs and sinks. Staff should wear rubber gloves while cleaning.

SHARP OBJECTS

Care should be taken with any sharp objects that can puncture skin. This applies to needles, broken glass, etc. These should be considered dangerous and handled with care. If such an object is used in client care (removal of a splinter for example) it should be disposed of afterwards.

DISPOSAL

Disposable items, gloves, sanitary pads, tissues, diapers, dressings, etc., should be placed in a heavy-duty plastic bag, tied shut, then put in a separate bag for disposal. This should be done routinely with bathroom trash.

EMERGENCY CARE

Airway devises should be dept in an easily accessible identifiable place on-site in each facility or home, and staff should be trained in their use. In case of the need for mouth-to-mouth resuscitation these should be used. These devises should be disposed of, following disposal procedures after use.

EXPOSURE

If a staff believes they have been exposed to either the AIDS virus or Hepatitis B through client care they should notify their supervisor immediately.

11/87 retyped for name change 3/30/90

[* THIS FORM IS TO BE POSTED FOR ALL TO READ]

CLIENT CONTRACT FOR STOREFRONT SERVICES

THE STOREFRONT IS DESIGNED TO MEET THE NEEDS OF RUNAWAY AND HOMELESS YOUTH. WHILE RECEIVING SHELTER SERVICES, THE CLIENT AND THE SHELTER PROGRAM AGREE TO THE FOLLOWING:

THE STOREFRONT AGREES TO PROVIDE:

1. **Overnight shelter** from 6pm - 8am, to include an evening meal at 7pm and breakfast in the morning. Storefront is closed for shelter from 8am to 6pm. Residents may have scheduled appointments, school, or other activities as set up by Storefront staff, allowing them to be inside the shelter between 8am and 11am.
   The length of your stay in shelter will be determined by your case manager after she/he has talked with you to find out what your needs are. If there are enough beds, you will be offered one of the following types of shelter stay:
   Short term (phase one): 3 nights shelter, 7 nights out, this cycle repeated as necessary. Short-term residents may have the opportunity to be considered for longer term shelter stay (phase II) as decided by the Storefronts case management team: You must show a desire and willingness in order to be considered for longer stays.
   Holds/or long term (phase II): Your case manager will determine your initial length of stay at the shelter after completing a detailed interview with you. This length of time may be extended or shortened depending on how you follow the case plan that both you and your case manager design for you. If you are a hold, you will be advised of how long you may be held at the Storefront. Depending on your needs, you are eligible to receive: weekly scheduled case meetings, independent living assistance and in-house school as appropriate. Your case manager may require you to participate in certain activities as conditions for receiving and keeping this longer term status.
2. **Staff supervision** from 6pm to 8am.
3. **Confidentiality** - information shared in counseling will not be shared with anyone other than shelter staff unless written permission is given by the client (EXCEPT : law requires that physical and /or sexual abuse be reported to the police and child protective services.)

THE CLIENT AGREES TO: (Clients must initial next to each rule, signifying that she/he agrees to follow it)

1. Obey the BIG FOUR rules:

-NO VIOLENCE: No physical fights between residents or against Storefront staff and volunteers either in the shelter or on the Storefront property. Both residents involved in the fight will be put out for one week if in for Holds/Long Term. Short-term residents (who have been on the 3/7 cycle) will be put out for two weeks.

_____
Client Initials

-NO WEAPONS: No weapons can be brought into Storefront at any time. If found, Storefront staff will confiscate the weapons and you will not have it returned to you. Holds/Long-Term residents will be put out of shelter for one week, Short-term, (3/7 cycle) residents, out for two weeks, if this rule is violated.

_____
Client Initials

-NO DRUGS: You may not bring in drugs or drug paraphanelia into or around the Storefront property. Holds/Long-Term residents will be put out of shelter for one week, Short-term (3/7 cycle)residents out for two weeks, if this rule is violated. Any

drugs or paraphanelia found will be confiscated and destroyed in your presence,
_____ by Storefront staff.
Client Initials

-NO SEX: No sexual activity, consentual or otherwise, can occur in shelter. Residents involved consentually will be put out for one week, if on Holds/Long Term and
_____ for two weeks if on Short-Term (3/7 cycle).
Client Initials

2. Honestly report your age. (New clients to the Storefront must be under 18 years of age.) Any client may be asked to obtain a Social Security printout in order to verify their age and birthdate. If you are asked to do this, and fail to present the printout,
_____ any further Storefront services to you will be denied.
Client Initials

3. NO LOITERING: No one receiving any Storefront services is permitted to wait, hang out, sleep, study, relax, etc., outside of the Storefront or within the neighboring property (no parking lots, no roofs, no front sidewalks, etc.). The Storefront is 'closed' from 11am until 6pm - you may not come by during those times, even if staff is inside, to use the restroom, get a jacket, drop off belongings, etc. It is urgent that you follow this rule in order for the shelter to stay in business. You will be denied all services if you break this
_____ rule.
Client Initials

Ex-Residents who break any of the above rules will not receive any services for two weeks (case managers may increase the amount of time if a client has continuously broken the rules).

THE CLIENT UNDERSTANDS THE FOLLOWING:

- If you are under 18, The Storefront must inform your parent or guardian of your location if you wish to stay at the shelter for more than three days.
- The Storefront is not responsible for any resident's belongings.
- A resident may be terminated for consistently breaking the major rules.
- A resident may choose to leave the program at any time and will notify the staff of this decision.
- The resident at any time and for any reason may file a written or oral grievance regarding Storefront services, staff, operations, etc, if they feel thay heve been treated unfairly. The Program Coordinator will respond to this grievance within a week's time.

I HAVE READ AND UNDERSTAND THE ABOVE CONTRACT AND I AGREE TO RECEIVE SERVICES WITHIN THE STATED GUIDELINES.

_____ DATE._____
RESIDENT SIGNATURE

THE STOREFRONT AGREES TO PROVIDE THE SERVICES AS DEFINED IN THIS CONTRACT.

_____ DATE:_____
STOREFRONT STAFF OR VOLUNTEER SIGNATURE

FAMILY HISTORY

Parent's Marital Status: Married _____ Divorced _____ Separated _____
Living together _____ Single parent home _____ Deceased ___
If parents are divorced or seperated, how old were you at the time? _____
Did either parent remarry? Mother ___ # of times ___ Dad ___ # of times ___
Describe your parents relationship with each other. i.e. open, closed, a lot of arguements, differences, things they did together _____

_____

_____

Do any of your family members drink heavily? _____ Who?_____
Do any family members use drugs? _____ Who? _____
To whom in your family are you the closest to and why? _____

_____

_____

Have you ever been abused? _____ If yes, by whom? _____
How old were you at the time? _____ What happened? _____

_____

_____

Are you currently being abused? _____ By whom?_____
Have you ever been molested/incest? _____ By whom? _____

Siblings	Age	Yes	No	Comments/description

_____

_____

_____

_____

_____

Decribe you family

_____

_____

_____

On a scale from 1 to 7, with 1 being the worst relationship and 7 being the best relationship, how would you describe your relationship with those that reared you? 1 2 3 4 5 6 7

Were you raised in any particular religion?_____ What?_____
Do you still hold those beliefs as true? _____

Page 3 Substance Use History

Substance	Age started	During peak how often used	How long	Last used
ALCOHOL				
MARIJUANA				
SPEED/ STIMULANTS				
DEPRESSANTS/ DOWNERS				
COCAINE				
PCP				
HEROIN				
OTHER				

Why do you usually get high? _____
Do you usually get high: Alone _____ with others _____ both____
Do all of your friends get high? yes ____ no ____ Most? yes ___ no _____
Were you allowed to drink at home? yes ___ no_____
If yes, how much and when? _____
Do you think you have a problem with drugs or alcohol? _____
Do you want assistance in this area? _____ _____
Have you ever been in counseling before? Yes___ no_____
If yes, where _____
When? _____
What type of counseling? individual ____ family ____ group_____
What was the reason you were in counseling?_____
_____
Did you find it helpful? _____ Why? _____

Page 4 Sexual history

Are you sexually active? yes ____ no ____ If yes, is it joyful? _____
frustrating? _____ painful? _____ a way to make money? _____
Have you been involved in survival sex? _____ _____
If yes, for how long? _____
Have you ever had to use sex as a way of survival? _____
_____
Do you currently have a pimp? yes ____ no ____ How much of your monthly income do you give to your pimp? $_____ How much of your monthly income do you keep? $_____ What is your average income? $ _____
What is your best estimate of the number of kids, male and female, who are under 18 in the San Diego area? _____
Do you use birth control? Always _____ Sometimes _____ Never _____
When you do, what do you use? _____
Have you ever had VD? yes _____ no _____ If yes, were you treated? _____
Where? _____ If no, have you ever been tested? _____
Do you consider yourself: straight _____ gay _____ bi-sexual _____ other ____
Since you have been out on the streets, have you had any health problems? yes ____ no ____ If yes, please describe the problems. _____
_____
_____
Which are current problems?_____
What do you do to survive on the street? pan-handle_____ drug sales _____
bum _____ sex _____ other _____

For females only: Have you ever been pregnant? yes _____ no_____
If so, how many times? _____ how many live births? _____
How many abortions? _____ How many miscarriages _____
Do you think you may be pregnant now? yes _____ no _____ If yes, have you had a pregnancy test. _____ Where? _____ How many months pregnant are you? _____

APPENDIX I

UNITED ACTION FOR YOUTH - Client Data Sheet

Date of Intake ___/___/___
Youthworker _____
UAY ID# ___ ___ ___ ___ ___

FOR OFFICE USE ONLY

Form # _____ Data Entered ___/___/___
Entered By _____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

Phone#: (___) ___-____

County: _____

Birthday: ___/___/___ Age: ___

Sex: ____ Race: A B C H N

Income: low mod high

School: IN OUT Grade: _____

School Name: _____

Social Worker: Yes No

_____

Court Officer: Yes No

_____

Parent Involved: Yes No
Name: _____
Phone #: (___) ___-____

Significant Others: _____

_____

_____

UAY Inactive: ___/___/___
Case Closed: ___/___/___

Referred By:

01 SELF
02 PEER
03 FAMily Member
04 Other INDIVidual
05 Youth CENTER
06 COURT
07 Law ENForcement
08 SCHOOL
09 SOCial Service Agency
10 OTHER

Initial Programs: Counseling Y N Prevention Y N

01 FITS
02 VICTim Support
03 Community ATTention
04 Runaway Homeless YA
05 CRIsis
06 High RISK
07 PREGnancy Prevention
08 FEDeral Prevention
09 COMPrehensive Prevention
10 SYNThesis

Living Situation:

At home with-
01 Two PARents
02 One PARent
03 BLENDed Parents
04 RELAtive
05 FRIEND
06 ADULT
07 HomeLESS
08 SHELter
09 Other TEMPorary
10 PLACEment
11 INDEPendent Living
12 Other LIVing

Issue at Intake:

01 NONE
02 RUNaway
03 HOMeless
04 Family CONflict
05 LEGAL
06 Mental Health
07 Emotional ABUse
08 TEen PARent
09 Substance ABUse
10 Physical ABUse
11 SeXual ABUse
12 NEGlect
13 PeerS
14 EMPloyment
15 Family PLANning
16 SUPervision
17 LEIsure Time
18 LIST _____

Significant Factors:

Check those which apply-

___ 01 S Risk
___ 02 H Risk
___ 03 Teen Parent
___ 04 Econ. Disadvantaged
___ 05 Public Assistance
___ 06 Female House. Head
___ 07 Disabled House Head
___ 08 Disabled Client
___ 09 Long-Term Phys. Pain
___ 10 Delinquent
___ 11 Pregnant
___ 12 C.O.D.A
___ 13 Synthesis I
___ 14 Synthesis II
___ 15 Synthesis III
___ 16 Victim
___ 17 UAY Filed ___/___/___
___ 18 Other Filed
___ 19 Substantiated
___ 20 Secondary Victim
___ 21 Sex. Assault (adults)
___ 22 Domestic Violence
___ 23 Intrafamilial
___ 24 Nonfamilial
___ 25 Violent Crime Victim
___ 26 DUI/DWI
___ 27 Homicide Survivor

Termination Reasons:

01 Client AGREEment
02 Client MOVEd
03 Client NON-compliance
04 Other STAFF recommendation
05 UAY STAFF recommendation

_____ Fee
_____ Billing Code
___/___/___ Billing Start Date
___/___/___ Complete Date

UPDATE

Dates: ___/___/___ ___/___/___ ___/___/___ ___/___/___

Youthworker(s) _____

FOR OFFICE USE ONLY

Form # _____ Date Entered ___/___/___

Entered By _____

Subsequent Programs: _____

Subsequent Issues: _____

Change Label: Yes No _____

Change Living Sit.: Yes No _____

Change School: Yes No _____

Change Sig. Facts: Yes No _____

Change Fee: Yes No _____

Subsequent Victim: Yes No _____

UAY Inactive: ___/___/___ Case Closed: ___/___/___

Reason: _____

INCOME INFORMATION

One person per household:

At or below $12,000 _____
At or below $19,200 _____
Above $19,200 _____

Two persons per household:

At or below $13,700 _____
At or below $21,950 _____
Above $21,950 _____

Three persons per household:

At or below $15,450 _____
At or below $24,700 _____
Above $24,700 _____

Four persons per household:

At or below $17,150 _____
At or below $27,450 _____
Above $27,450 _____

Five persons per household:

At or below $18,500 _____
At or below $29,150 _____
Above $29,150 _____

Six persons per household:

At or below $19,900 _____
At or below $30,900 _____
Above $30,900 _____

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